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Preventing Mental Retardation

The Community and Its Schools

About Delinquent Girls

Nutrition of Adolescents

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◀

> *This is still the greatest Nation in the world in which a child can be born and raised. His freedom, his security, his opportunity, his prospects for a full and happy life are greater here than any place on earth. . . .*
>
> JOHN F. KENNEDY, in his message to Congress on our Nation's youth, February 14, 1963.

John H. Fischer, who has a doctorate in education from Johns Hopkins University, was superintendent of schools in Baltimore before becoming dean of Columbia University's Teachers College in 1959 and then college president in 1962. He is a member of the panel on educational research and development of the President's Science Advisory Committee; and is chairman of the executive committee of the National Scholarship Service and Fund for Negro Students.

Muriel Crosby went to Wilmington, Del., to become assistant superintendent of schools in 1951, the year she received her doctorate in education from the University of Maryland. In this capacity she administered the 3-year project of schools in changing neighborhoods described in her article. Previously, she taught at Adelphi College.

Dr. Arthur J. Lesser has been with the Children's Bureau for 23 years, serving first as a specialist for crippled children and, since 1952, as director of the Division of Health Services. A pediatrician with a master's degree in public health from Harvard University, he came to the Bureau from the New York City Department of Health.

Otto Pollak's background includes 7 years' experience as social science consultant with the Jewish Board of Guardians of New York, and 5 years as research consultant with the Family Service of Philadelphia. He currently directs a graduate training program dealing with sociology of intervention systems and is associated with a family counseling project at the Philadelphia Psychiatric Hospital.

Gisela Konopka, who has a master's degree in social work from the University of Pittsburgh and a doctorate from Columbia University, has been with the University of Minnesota since 1947. Her many writings, focused chiefly on social group work, have included a previous article in CHILDREN, "What Houseparents Should Know" (March–April 1956).

Penelope S. Peckos (left), who has worked with children and adolescents at the Forsyth Dental Infirmary for Children for the past 15 years, is presently participating in a longitudinal growth study of twins and their siblings, being conducted at the clinic. In addition to directing the adolescent unit of Children's Hospital of the District of Columbia, Dr. Felix P. Heald (right) is associate professor of pediatrics at Georgetown University School of Medicine.

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I. The Community's Responsibility

JOHN H. FISCHER
President, Teachers College, Columbia University

MUCH OF THE TALK about education today appears to rest on the assumption that our educational requirements are very much alike the country over. Starting here it is logically easy to take the next step and look for a national remedy to whatever ails us. And so we are being urged to adopt national standards and to use them not only as yardsticks, but also as persuaders to bring the laggards and the nonconformists into line. Closely related, and not entirely by accidental coincidence, are the schemes to set up national curricula and to deliver expertly prepared, neatly packaged courses in individual subjects.

It would be absurd to argue against a national view of our educational concerns or against efforts at the national level to deal with them. The fact is that the whole country faces serious common problems and conditions, many of which impinge on schools and depend for their ultimate solution on education.

One has only to read the report of the President's Commission on National Goals [1] to be reminded of this truth. In virtually every field with which the Commission dealt, from the role of the individual to the strengthening of the United Nations, education was identified as a major element, and often as the critical component in working toward better solutions.

We must recognize the national dimension of our educational concerns and use at the national level both governmental and nongovernmental procedures to deal with them. But here I should like to reverse the coin and examine for a brief time the place of the school not so much in the Nation as in the city, the village, the local school district. Given our traditions, our disposition as a people, and our still quite diversified States and communities, uniform national programs offer no satisfactory answer. We must strengthen our local efforts as well as our national programs, and we must interrelate as effectively as we can the resources and the possibilities of governmental and private agency activity at every level.

In no aspect of government are Americans more insistent upon the values of local action than in the management of schools. We sometimes forget, however, that the reason for delegating the sovereign educational authority of the State to the local school board is not to authorize local lethargy. It is rather to empower those nearest to their schools to exercise superior initiative and so enable the schools to carry out better the State's obligation to educate its citizens. The strength of local control is only as great as the wisdom, the intelligence, and the responsibility with which local decisions are made and put into effect. The principal reason for the current insistence on more national action to improve American schools is the evidence that too many local communities are unable or unwilling to exercise the options available to them.

The school is only one of many agencies designed to serve youth and if we are to deal wisely with the school, we must consider the total context of the community in which it operates. Even more important,

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Dr. Fischer's article is based on a paper presented at the 1963 spring meeting of the National Social Welfare Assembly.

we must focus our efforts upon the individual child and what happens to him. Ordinarily we use as a guiding principle *equality* of opportunity. That concept is seriously limited—and limiting—however, unless we think at the same time of the *quality* of the opportunity the community offers its children.

Considerations of Quality

If we are to approach intelligently the problem of affording all American children at least basic opportunities of suitable and comparable quality, we must consider what elements make for qualitative differences in the conditions children face and in those they require for sound development and useful learning.

The overriding reason for doing everything we can to help a child to make the most of whatever potentiality he has is neither political, social, nor economic. The fundamental reason is moral. We owe the child the best we have in our power to give him simply because he is a human being and because we share responsibility for his welfare.

It may be argued that no such assertion is necessary since its acceptance can be assumed in our society without special justification. The sad truth is that the differential treatment of children in our country offers an embarrassing abundance of evidence to the contrary. Children are being discriminated against in the United States in many places where the things that happen to them day in and day out fall far short of the purposes we proclaim in our historic documents and of the basic moral principles by which the best human relations are always governed. We continue our attempts to rationalize our unfair treatment of certain children on grounds of legal technicality and administrative convenience, but the moral issue remains starkly clear and unresolved.

Wherever a shortcoming in any child's opportunity is due to discriminatory treatment, the measure of the corrective action required must ultimately be the moral measure.

Nor can application of the moral criterion in the treatment of children be limited to issues stemming from laws and courts. The moral standard is not only relevant, but inescapable in every situation where the child as a person is involved. In classrooms, on playgrounds, in social agencies, in reform schools, wherever children are met and served, the most telling test that can be applied is to ask whether each child is given the respect and acceptance due a human personality.

The moral criterion is basic even—one might say *especially*—in situations where opportunities may be technically adequate and equal. Unless the child is valued in his own right, he is not likely to respond well to any stimulus, however efficiently a program may be administered, staffed, or financed. The quality of our attitude toward children inevitably colors all our relationships with them and affects both their immediate reactions and the long-term development of their own attitudes toward others.

Respect for the individuality of children has in addition to the moral basis an equally relevant psychological aspect. Although it is a truism that no two children are ever alike, the truth seems frequently to escape us. We constantly set up institutional arrangements without taking into account the differences among children or the variety in their backgrounds, their abilities, their ambitions, their hopes, and their fears.

Nor is it enough to recognize that children differ from each other. The same child will vary from stage to stage in his own development. A boy at 14 is quite a different person from the youngster he was at 8. Productive work with children requires us to know and be sensitive to the developmental tasks each child must meet as he matures from infancy to adulthood. We must take into account at every appropriate point the physical, mental, and emotional effects of our laws, our institutions, and our practices.

A third consideration in the quality of the opportunities we give children is the cultural element. The child is born a member not only of the human race in general, but of a family, a neighborhood, a community. At the instant of his entry into the world, he is surrounded at once by the culture into which he has been born. He is handled, clothed, fed, and spoken to according to patterns fixed long before his arrival. The values he learns, the fears he acquires, the courage he develops, the ambitions that he feels will be materially influenced and often completely shaped by the heritage of practices and purposes that permeate his home and the community surrounding it.

In a society as complex and as rapidly changing as ours, the occasions for cultural conflict in the life of a child are numerous. But at the same time the cultural resources to nurture a child's growth and enhance his education are rich and widely available. It remains constantly true, as Walt Whitman observed, that when the child goes forth all that he looks upon he becomes. But how he assimilates what he sees, how he uses each experience, is controlled in large part by the nature and quality of his previous experiences. This is why the role of the school and the work of the teacher are so crucial in today's world. One of the chief responsibilities of the school is to help the child understand, interpret, and organize what he observes; in brief, to learn from his experience. If the school is unable to do this, the child may find the world not a richly diversified opportunity for self-development and expression, but a deeply disturbing chaos.

A fourth factor in the qualitative improvement of opportunities for children is the economic element. Many of the opportunities children may enjoy depend very directly on the wealth of the families or the communities in which they happen to live.

Any discussion of the economic element in relation to children's opportunities must involve the question of values. Whenever, in our families or in our national councils, we find ourselves with anything more than the essentials for food, clothing, and shelter, we must decide how to use what we possess. Inevitably we use it for what we believe to be most important or most desirable. Often in our families we profess one value system and live by another. The same conflict exists in our communities and on a national scale.

No thoughtful person would argue that money can solve all our youth problems, for it is clear that some of them are aggravated by the unwise use of money. But the evidence is abundant and clear that many of the ills that affect our young people could be materially corrected and the quality of their opportunities substantially improved if we were to apportion to education and other youth services a part of the national productivity that we now commit so liberally to trivial and often harmful nonessentials.

Roads to Improvement

If we accept the proposition that the quality of our children's opportunities can be improved by serious attention to the moral, psychological, cultural, and economic elements which shape them, there still remain questions of practical application. Where and how can we move to bring about the necessary improvement?

There can be little doubt that the central point for affecting the development of most children is the home. When the home life of the child is sound and wholesome, he is able to deal with even quite serious inadequacies in other situations. Most families, fortunately, meet their responsibilities without special help. Yet even the strongest family can scarcely claim to be entirely self-sustaining or self-controlled, for every home is influenced by a multitude of environmental forces ranging from the prevailing mode of teenage dress to the current state of our international relations.

> *. . . As a nation we can be proud of all that we have done for our youth—in improving their opportunities for education, health, employment, recreation, and useful activity. All Americans recognize that our children and youth are our most important asset and resource. But there are few resources in this country with a potential so largely undeveloped.*
>
> *We cannot be complacent about the impediments to their development which still remain, about the opportunities they are denied, about those segments of our youth population not enjoying the opportunities enjoyed by others. If, for the sake of our Nation as well as their own families, our children and young people are to grow into productive adult members of society and bear the responsibility of the legacy we leave them—that of the world's most powerful and economically advanced nation—then all of them must have the fullest opportunity for moral, intellectual, and physical development to prepare adequately for this challenge.*
>
> JOHN F. KENNEDY, in his message to Congress on our Nation's youth, February 14, 1963.

Many, though certainly not all, of those currents of influence are set in motion by the organized agencies of our society and can accordingly be altered by these agencies when they choose to do so. Thus publishers, advertisers, and television broadcasters possess enormous power and carry commensurate responsibility for the quality of opportunities available to children in their homes. In less dramatic ways, churches, libraries, social agencies, and other groups can also contribute to strengthening the best homes and improving weaker ones.

To buttress the family, or occasionally to substitute for it, health and welfare services in sufficient variety and at a proper level of intensity and quality are essential. Not only should each of these types of service be well-planned and administered, but the entire complex of offerings needs to be intelligently integrated as a community-wide effort as their influences are brought to bear upon an individual child or his family. The work of the schools, the courts, and the correctional institutions can be made much more fruitful when they operate in proper relationship to each other.

The rapid increase of urbanization with its effect upon family living underscores the need for expanded and improved recreation services and other activities to help children use their leisure time profitably and productively. One advantage of recreational services often overlooked is that they place young people in situations where they can make choices of their own and engage in voluntary commitment to worthwhile organizations, activities, and causes. As supplements to schools, churches, and families, such organizations are an essential part of modern life. They should be supported, staffed, and financed at levels that will lead to the highest possible accomplishments.

Of all the ways in which to improve the quality of the opportunities available to our children, the one with the greatest effect over the longest period of time upon the largest number of children is education.

Educational Goals

Despite the varied philosophies from which they spring, most statements of educational goals, when the jargon has been filtered out, may be reduced to two main purposes. One is self-realization and the other is social effectiveness. Or, to put it differently, we create schools and bring children to them in order to help each child make the most of himself, as we teach him the essentials of the culture so that he may carry forward for one more generation the knowledge, the techniques, and the values that comprise the culture.

The child begins to acquire something of this social heredity very soon after he is born. He acquires it first from his parents, then from others in the family and his playmates, and, as he grows older, from a variety of institutions. If the school is to make its best contribution to the child and to society, its unique role must be defined and its resources used with deliberate economy to carry out that role.

The school, beyond all other agencies, is expected to teach the child the systematic use of language. The child first learns to speak and to understand speech in his home, but his introduction to the linguistic system—reading, writing, spelling, the composition of thought into organized and effective expression—is the work of the school. This task is assigned to teachers who have studied and mastered the techniques for building such competencies.

The child first becomes aware of quantity as one aspect of experience in his early contacts with things at home. But in the school he learns of number systems, of mathematical symbols and relationships, of mathematics as a way of interpreting experience and expressing imagination and calculation.

Similarly, the child discovers before he comes to school that he is surrounded by objects and phenomena that interest and puzzle him. Sometimes these natural manifestations frustrate and frighten him. The function of the school is to help him understand them, to relate them to each other, and to differentiate them from each other in sensible classifications. Here he comes to see the connection between cause and effect, learns to distinguish fact from opinion, and to form dependable generalizations which remove some of the uncertainty from random experience.

The school helps the child to see himself in his social setting, to know himself as a unique person among other persons. In school the child begins to acquire the concept of social continuity, to understand how he is related to others in space and time. Gradually his social horizon expands and his understanding deepens as he learns of other human beings who live with him in the family, the classroom, the neighborhood, and in the wider circles of the community, the State, the region, the Nation, and the world. Now, as the space age dawns, we have in our schools children who as adults will be concerned with relationships beyond the earth.

The school has its part to play, also, in teaching the arts by which we live, the mastery of tools and techniques for controlling, shaping, and using the physical environment. For a substantial number of children, the school also has the task of teaching skills directly marketable in industry and commerce.

No list of the school's proper functions is complete if it does not include the fine arts. Developing the aesthetic capacities of children and teaching them to appreciate beauty in music, the drama, the dance, the plastic and the graphic arts is as *fundamental* as any of the other subjects to which that honored adjective is customarily applied.

But perhaps more than anything else, we adults want the school to teach the child our value system and to encourage his commitment to the values we hold important. This is the province of the humanities and the place where it becomes most difficult to distinguish the role of the school from that of the home, the church, or the community as a whole. But we look to the school particularly to embody in its work a tone, and an emphasis produced by deliberately selected materials and methods of instruction that will foster respect for truth, goodness, and beauty, and will build in young people a sense of personal responsibility to reach for the best.

The Social Dimensions

It is sometimes argued that the school should be charged with nothing but the intellectual development of its pupils. If such a school were not psychologically impossible, it would be morally irresponsible. The human mind is not a separate entity, to be trained apart from the body or the emotions. All learning is colored by the emotional condition of both the teacher and the pupil and, in turn, sets up emotional interactions between them.

The only defensible course is to acknowledge that every teacher to some degree shapes his pupils' personalities, to take this influence responsibly into account, and to make the wisest possible provision for it in the program of the school.

Since the human mind can be developed and made effective only through contact with other minds, intellectual development always has its social dimension. It, therefore, follows that all instruction aimed at intellectual competence should be offered with full awareness also of its moral implications and its social consequences.

The school, in brief, has many functions to perform, for the child, for the family, for the community, and for the Nation. Its mission should not be made to appear simpler or narrower than it properly is. But neither should it be expected to assume responsibilities that belong more appropriately to other agencies. The wisest course toward a sound community establishment of services for young people lies in the direction of joint effort. When all agencies combine to define their respective functions and simultaneously to build a network of relationships so that they may communicate and cooperate, the results are certain to be good.

It is precisely in such community-wide collaboration that the special benefits of local initiative and local control are best revealed and best used. This is not to deny the urgent need in many places for help in the form of financial support and supplementary services through State and national agencies. It is to argue that the most effective way to integrate services, to tie together public and voluntary activities, and to bridge over the gaps between professional specialties is, through local leadership, to concentrate the available resources upon the problems of raising to the highest possible level the quality of services provided to meet local needs.

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[1] The American Assembly, Columbia University: The report of the President's Commission on National Goals. New York. November 1960.

> **. . . If we indoctrinate the young person in an elaborate set of fixed beliefs, we are ensuring his early obsolescence. The alternative is to develop skills, attitudes, habits of mind, and the kinds of knowledge and understanding that will be the instruments of continuous change and growth on the part of the young person. Then we shall have fashioned a system that provides for its own continuous renewal.**
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> *"Renewal in Societies and Men," John W. Gardner, in the* Annual Report of the Carnegie Corporation of New York, *1962.*

II. An Adventure in Human Relations

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NOWHERE are social changes in a city reflected so clearly as in the inner life of its schools. When these have been rapid and sharp as they were in Wilmington, Del., in the decade of the fifties, the school's task of educating the young may become so complex as to have a demoralizing effect on the entire school system. Four interacting social factors—in-migration of the poor, out-migration of the better off, desegregation, and teacher shortage—were leading to such an educational impasse in Wilmington when in the fall of 1959 the Three-Year Experimental Project on Schools in Changing Neighborhoods [1] was set up to counteract it.

In the decade of the fifties the population of Wilmington had dropped from approximately 112,000 to some 97,000. Yet the child population had increased from 6,773 to 8,000. At the same time the proportion of Negro children in the elementary school population rose from 11 percent to 54 percent. Most of these children came from families of low economic and educational status. Formerly confined almost entirely to one area of the city, many of these families had fanned out across the city when their homes became marked for demolition to make way for an urban renewal project; and in their new neighborhoods, once "middle-class white," they had been joined by many Negro in-migrants from other States who had come to Wilmington in search of employment. Since the racial desegregation of the schools in September 1954, their children had been attending schools formerly attended by white children, most of of them from middle-income families.

There had been changes, too, in the characteristics of white families whose children attended the public elementary schools. Middle-income families were moving to the suburbs and their places were being taken by low-income families, often newcomers from economically depressed areas, chiefly rural, lacking skills and "know-how" for city living.

In a short space of time, Wilmington had become a city of increasing poverty, with 25 percent of its families living on less than $3,000 per year. At the same time, it had retained its position of great wealth whose representatives worked in the city but lived in the suburbs.

As these population changes took place, the characteristics of the school children changed, resulting in changing problems for the schools:

- With 65 percent of the children lacking any medical care, an increased percentage of the school budget was required for health services.

- Hungry, malnourished, poorly clothed children demanded increasing welfare services of the school staff.

- Since deprivation increases emotional problems, increasing numbers of children exhibited serious blocks to learning.

- There was a marked increase in aggressive behavior as children from disadvantaged families, where fighting is an expectation, replaced the onetime middle-class school population.

- The children and their teachers were not communicating. Deprived children have little experience with books, little command of standard English, and lack experiences that prepare children for academic learning.

As a result of these changes, many teachers found that they were unable to help children to learn, a task they had not found difficult with children from middle-income families. Therefore, many of them gave up and sought more comfortable positions in the suburbs, thus compounding an already acute teacher shortage for the city's schools.

The Three-Year Experimental Project on Schools in Changing Neighborhoods was set up under the joint sponsorship of the Wilmington Board of Public Education and the National Conference on Christians and Jews. It had two main goals: (1) the improvement of the schools through the development of appropriate curriculum and inservice teacher education to meet the human relations needs of the children and to stimulate motivation for learning, and (2) the upgrading of family and community life through the development of indigenous leadership. Thus the project design had two aspects: (1) the school-centered aspect, and (2) the community-centered aspect.

The School-Centered Aspect

The school-centered aspect included a teacher education program designed to help teachers change their attitudes toward children, provide them with techniques for diagnosing the human relations needs of children and their families, and learn ways of developing curricula appropriate to these needs. Its design was based on the belief that if children saw use value in what they were taught their motivation to learn would be increased and their academic achievement would be greater.

In the first year of the project, 6 of the city's 14 elementary schools decided to enter the project, and 65 of their teachers enrolled on a voluntary basis. At the beginning of the second year, 5 more schools joined, making 11 in all, with approximately 165 teachers enrolled from a staff of 275 teachers. Other staff members participated, but the key of the project's success was in reaching the classroom teacher who works directly with children. The project's holding power proved to be excellent due to the outstanding work of the consultant provided by the National Conference of Christians and Jews, the late William E. Vickery, who died at the beginning of the project's third year.

Project schools were organized under the direction of each principal. The consultant visited each school 2 days per month during the first year of the project and 4 days per month during the second year. During the first year, systemwide meetings of all participants were held after school on a monthly basis, enabling the consultant to develop the use and treatment of diagnostic data related to children's perceptions. The remainder of the consultant's time was spent in schools working directly with principals and teachers in group and individual conferences. After the first year, all consultant work was carried out in the schools, providing help in curriculum planning and developing effective teaching processes. Upon Dr. Vickery's death, consultant services were continued by the supervisory staff of the schools and the volunteer help of Agnes Snyder, a retired educator. Throughout the project there was little released time from their normal tasks for participating teachers, but principals were ingenious in providing conference time for them.

The teachers were taught the use of diagnostic instruments, including sociograms, diaries, time budgets, autobiographies, and open-end questions. The open-end questions became the favorite and most used instrument. For example, the children were asked: "What do you like about your neighborhood?" "What would you like to change?" "What is the best thing that could happen to your family?" "What is the best thing that has happened to you?" "What is the worst thing that has happened to you?" "What do you like about the grown-ups you know?" "What would you like to change about the grown-ups?"

Younger children responded in drawings and older children in writing. Their responses were analyzed by their teachers, who built teaching units on the needs revealed.

For example, one first grade teacher in a lower middle-income neighborhood discovered that only 6 of her 30 children lived with both parents. Home conditions were revealed by the children's response to the question: "What would your father say if he came home from work and found the breakfast dishes in the sink?" Only one child responded with, "Mama must be sick." More typical responses were: "Drunk again," "On the telephone all day."

These and other clues revealed to the teacher that the typical picture of the family, with its lovely cottage, white fence, both parents, and friendly siblings, found in most first grade books, was entirely foreign to the children. This teacher built a teaching unit on family life on several premises:

- That a home is made by the people in it.
- That the composition of families differ. For some, a family is a mother and child; for others it may be grandmother and grandchildren, a father and children, or simply "the lady who takes care of you."

A fifth grade teacher found that all the children in his class came from families who had been forced to move from their old neighborhood because of an urban renewal project. This teacher usually studied the westward movement with his children, giving them a deep feeling for the folk material, the tales, the poetry, music, artifacts, and dances of the people on the trail. He continued to do this, but went further—suggesting that all folk material tells much about the people who created it. As the children analyzed the folk material, they discovered that usually there were expressions of longing for what had been left behind as well as delight in the new.

The teacher next suggested that because all of the children were living in a new neighborhood there must be things they missed from their former homes. There were: the corner store that gave you credit when the relief check failed to arrive on time; the neighbor who baby-sat for you so that you could go out to play, knowing that your little brothers and sisters were being watched; the farmers' market where at the end of the day the farmers sold produce cheaply rather than return home with it; the store front church where "you could get happy on Saturday night." These were the "familiar" the children missed.

The children recorded pleasure in the new too: the home in the housing development never without heat in winter, thus making it possible to take a bath when you wanted to; a bedroom you shared with only one other person; a closet for your clothes; play space; no rats or leaking roofs.

Thus, these children made the discovery that they could identify with the pioneers who came before them. The pioneers were no longer just people in books. The American heritage became real to the children, and their understanding of themselves and others was deepened. What is read in a history book is soon forgotten; what is felt becomes part of you.

The teachers of one school in an inner city blighted area, part of which was slated for urban renewal, took a walking tour of their school district in order to get a better idea of the environment in which their pupils lived. They found negatives—battered sidewalks, houses in obvious disrepair, garages used as houses, many taverns and liquor stores, idle men, bad odors from a leathering processing plant; and many positives—churches, schools, a park, some well-kept homes, friendly people. One teacher reported:

> As I walked our tour, there was one thing which made me pause. It was the feeling of uncertainty which seemed to permeate the air. Even though I am acquainted with the development of Project A (urban renewal project), at times I am still startled by this part of the East Side's new look. Knowing how much the familiar helps to establish stability in our lives, I wonder what the children or even the adults think or feel when they look at all the shattered buildings and empty spaces around them. While this situation is only temporary and the buildings will be replaced, it still means that a way of life in this community is slipping away. While progress is good, often many problems accompany it. I feel that for quite a while to come we will have to bear the brunt and deal with the children of this unsettled community. However, with thoughtful awareness, a little insight, and a great deal of patience, we will meet this challenge.

The Community-Centered Aspect

In initiating the Three-Year Experimental Project on Schools in Changing Neighborhoods, the school authorities knew that the schools could not do the job alone; that cooperative action with other agencies and organizations serving people was an imperative if conditions conducive to learning were to prevail. Therefore the community aspect of the project was initiated. An invitation to various groups to join the school staff in this effort secured a warm response from some 65 agencies and organizations, among which were churches, settlement houses, the youth aid division of the Police Department, the Welfare Council, the Girls' Club, Boy Scouts and Girl Scouts, the American Association of University Women, the National Association for the Advancement of Colored People, the State university, the local housing authority.

The structure for action was informal. No attempt was made to create another organization. Conferences were held in which each agency and organization attempted to find ways of helping people help themselves through its own program. No funds were available to secure a professional community organizer, but consultation was provided by the National Conference of Christians and Jews.

During the first year of the project, community participants met for four afternoon sessions in which consultants in community organization discussed ways of discovering and developing indigenous leadership. In the second year, a 4-day workshop was provided by the National Conference of Christians and Jews in which Juanita Cogan of the School of Social Work, Rutgers University, acted as consultant in the development of a plan for action in coordinating agency efforts to serve families in the city. During the next 2 years, a series of monthly meetings was held for sharing reports of progress and securing interagency assistance where needed.

What has been accomplished is a stirring story of dedication and commitment to people and to a community:

- Wilmington, which had only 2 functioning neighborhood councils in 1959, now has 14 councils. These have joined together in a federation. The first council growing out of the project, the Price Run Community Council, waged and won a year long battle to prevent the passage of a new housing code which would have permitted changing single family homes to multifamily houses.

- The Young Men's Christian Association has established in 8 of the 14 elementary schools of the city Gra-Y Clubs for boys 8 to 12 years of age, and plans to have clubs in all schools in 1963–64. These clubs meet twice a week after school.

- The Young Women's Christian Association has established Preteen Clubs for older girls in three of the schools.

- The Girls' Club has established branches in two schools.

- Sixteen college-educated women, representing the Junior League, the American Association of University Women, the St. John's Episcopal Church, and the Unitarian Church, serve as volunteer teacher aides in four schools, 2 days per week throughout the school year. They bring to children needed personal interest and the knowledge that somebody cares about them.

- Clothing, money for free lunches, and magazines are contributed to the schools regularly by six church groups or women's organizations.

- Several groups are "adopting" deprived children on a family basis, with each family represented in the groups taking children of a deprived family to the theater, on trips to points of interest, and giving them other experiences that show children the doors to wider worlds.

This is only a sampling of the tangible outcomes of the community aspect of the project. More important is the "intangible," the quality of relationships and support given the schools and other agencies by the community at large. The project has, in fact, been like a pebble in a pool! Since it first aroused people to action in 1959, an increasing number of organizations, institutions, and lay groups are taking positive action on their own initiative in behalf of deprived people. And most of these have communicated with the project participants. The fact that each participant in the project holds memberships in many other groups has helped to swell the tide of interest in making the city a better place for families and children to live.

The following reaction of one agency director to participation in the project reveals the influence of cooperative action:

> As a new director of a long established agency, I followed leads I obtained in this group (a group of project participants). I surveyed needs in our inner city center and found that we were duplicating services of other agencies in our neighborhood. I found that our second center, located in south Wilmington, is the only agency in the area. We are concentrating all our efforts next year in the south Wilmington area. We are enlarging our facilities and planning with the principal and staff of the neighborhood schools. We have secured help from the women in the neighborhood who will clean and polish; the men are building shelving and making other improvements. We expect to establish a youth study center and other service facilities. Only through work with this group would I have gained the insight needed and the help to bring to fruition a major new program of service.

The Proof Is in the Eating

To assess a human relations project requires confidence in the subjective as well as in the objective evidence available. Our observations lead us to believe that while the formal 3-year project ended more than a year ago its influence continues both in the schools and the community. We see this in:

- *Improved teacher morale.* Teachers identify with their children, believe in them, and take pride in their accomplishments. While before the project the total number of staff vacancies averaged 35–40 per year, in the last 2 years of the project this average dropped to 20.

- *Improved behavior in the inner city schools.* The children's behavior in these schools is not noticeably different from the behavior in schools in more privileged locations. In 1961, of some 600 cases of antisocial behavior of children and youth in the city of Wilmington serious enough to be held for court action, less than 200 of the youngsters involved came from low-income families; all the others came from middle and upper income families.

• ***Improved communication between teacher and pupil.*** We have discovered that informal standard English is the greatest block to learning experienced by disadvantaged children. They have a dynamic, exciting, natural language which has usually been frowned upon by the teachers so that the child has been bereft of the only means of communication he knows. Teachers who have participated in the project accept the child's natural language and use it appropriately. But they also teach the child that other ways of saying the same thing are appropriate in other situations, for unless the child learns informal standard English, he will remain on the lowest rung of the economic ladder.

One school is continuing a study it began under the project of ways of developing children's language power. The children of this school, who used to gain only a 6 to 8 months' achievement level a year in standard tests, have for the past 3 years been gaining a 1-year, 1-month achievement level. This same group is achieving nearly 2 years' growth in vocabulary each year. This study will be completed in 1968.

• ***An increased understanding of the ways of deprived families.*** We have identified what may be one of the blocks to self-sufficiency among many deprived families—an inability to understand the relationship between cause and effect. Many low-income families do not anticipate problems. They live relatively "high on the hog" for a few days after receiving pay or their relief checks and have little to eat for the remainder of the week. We found this inability to understand cause and effect among their children. The children from middle income families usually saw a reason for people's action. They would explain that the thing they did not like about adults was "the neighbor who yelled at you—but he likes a nice yard." The deprived child showed dislike for the same type of adult behavior, but he seldom gave a reason for it.

A junior high school principal told of his disappointment when only a few parents attended a spring meeting for orienting parents to the new school their children would attend in the fall. One of the elementary school principals explained, "Parents in our school do not anticipate problems. Now, the children are being promoted so there are no problems. If you plan a meeting for the parents 6 weeks after school opens, most of the parents will attend."

Through this project we have evidence that education based on problem solving, on thinking through to possible solutions, on anticipating the probable outcomes of different courses of action, on experiencing the effects of choices, can make a difference and perhaps block the perpetuation of a life pattern which renders people ineffectual in controlling their own destiny.

• ***An increased appreciation of the strengths in people.*** We have found that many parents in spite of the degradation of poverty provide a family climate of love and warmth. We have also found that mobility in people does not necessary denote rootlessness but often a searching for a nourishing soil within which one's roots can thrive.

Problems of Administration

The greatest problem encountered during the project, and one never fully solved, was one of financing. While the National Conference of Christians and Jews provided some funds for specific services, the project had no complete underwriting, and so was unable to undertake the research which was part of the original project design. Even more unfortunate has been limits put by insufficient funds on the variety and amount of enriching experiences that could be offered to the school children.

On the plus side has been the devotion of the project participants—members of the Board of Education staff and community agencies, who carried out much of their project work on unpaid overtime.

The educational problems of our inner city schools have certainly not been solved by this short term inadequately financed project. But a pebble has been dropped in the pool and its ripples are still extending outward. We have demonstrated that much can be achieved without money, by utilizing available resources in a variety of ways, and by emphasis on inservice teacher education. But we have also learned more fully how much remains to be done. As Walt Whitman has written, ". . . it is in the essence of things that from any fruition of success, no matter what, shall come forth something to make a greater struggle necessary."

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[1] Wilmington Public Elementary Schools: An adventure in human relations—a three-year experimental project on schools in changing neighborhoods. Wilmington, Del. 1st year report, 1959–60; 2d year report, 1960–61; and 3d year report, 1961–62.

The 1963 maternal and child health and mental retardation amendments to the Social Security Act place an . . .

ACCENT ON PREVENTION THROUGH IMPROVED SERVICE

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ON OCTOBER 24, 1963, almost exactly a year after he received the report of the President's Panel on Mental Retardation,[1] President Kennedy signed a bill which lays the groundwork for a broad attack on the problem of mental retardation along four major fronts underscored in the Panel's recommendations: preventive service, care and treatment, research, and community planning. As already reported in CHILDREN (see November–December 1963, page 243), the statute amends the Social Security Act to authorize:

- Increasing from $25 to $50 million, over a 7-year period, the ceiling on grants to the States for maternal and child health services, beginning in 1964 with an increase of $5 million a year.
- Similarly increasing the ceiling for grants to the States for crippled children's services to a maximum of $50 million in 1970.
- A new 5-year program of grants up to 75 percent of cost, to public health agencies for prenatal, delivery, and postnatal care for mothers and their infants regarded as facing special health hazards and unlikely otherwise to receive such care. The total authorization for this program is $110 million, in steps of $5 million in fiscal 1964, $15 million in 1965, and $30 million each year from 1966 through 1968.
- A new program, up to $8 million a year, of grants, contracts, or cooperative arrangements for research relating to maternal and child health services and crippled children's services.
- A onetime appropriation of $2.2 million for grants to the States, up to 75 percent of the cost, for planning comprehensive programs of prevention, treatment, and amelioration of mental retardation.

Under delegation from the Secretary of Health, Education, and Welfare, the Children's Bureau will administer the grants for maternal and child health services and crippled children's services, as it has in the past, and also the grants for special maternal and infant care projects and for research. The planning grants are to be administered by the Public Health Service.

Behind the broad scope of these provisions was the realization, spelled out clearly in the Panel's report, that the accent in any program to reduce and alleviate the increasingly vast problem of mental retardation in this country must be on prevention—prevention of the physical conditions in mothers and infants that lead to mental retardation and prevention of the social and emotional conditions that block the development of whatever potential retarded children have. Both types of prevention, generally known as primary and secondary, come from two directions—applying what we know, and finding out what we do not know.

Primary Prevention

The goal of primary prevention is to give the child a healthy start in life. Important channels for reaching this goal are the maternal and child health services provided by the States and localities with the help of Federal funds made available under the Social Security Act.[2,3] These services, which the new amendments open to expansion, have implications for maternal and child health far beyond the prevention of mental retardation. Focused largely on the provision of prenatal and postnatal care, well child supervision, immunization against communicable disease, school health examinations, dental services, and clinical services for mentally retarded children, they have undoubtedly played a major role in the reduction of infant and maternal mortality over the years and in the prevention and alleviation of disease and disability in infancy and childhood. They have not, however, generally kept pace with increases in the child population, with advances in medical knowledge in some respects, and with increases in the costs of professional service. Hence the need for expansion in all their aspects.

Basic to reducing the incidence of retardation associated with childbearing is the expansion of maternity services. As is pointed out in the report of the President's Panel on Mental Retardation, the prevalence of mental retardation is higher in population groups having inadequate maternity care. The rate of premature births is highest among these groups, and the incidence of mental retardation is substantially higher among premature infants than among full-term infants.[1]

It is not difficult to guess who the groups of women are who receive inadequate maternity care. They are, in simple terms, the poor.

According to an AFL–CIO study of 1958 incomes, there were more than 41 million people in the United States, or 24 percent of the population, in families with incomes under $3,000 a year. However, if poverty is defined by the lower criterion of having an income of not more than $2,500 for a family of four, and proportionately higher for larger families, then 19 percent of the population, or 32 million people, are poor.[4] Where these families are might be surmised by a look at recent infant mortality rates, another indication of inadequate maternal and infant care.

In 1960, nine of the 10 largest cities in this country had infant mortality rates exceeding the national rate of 26 per 1,000 live births. In 7 of these 10 cities, there were increases in infant mortality rates between 1950 and 1960, ranging from 5.6 percent to 26.4 percent. In nonmetropolitan counties—those with centers of population smaller than 50,000—the infant mortality rate in 1960 was also higher than the national rate.

These data point to a concentration of problems of maternal and child health in the larger cities and in the rural counties. This has always been true of the rural areas; what is new is the growing seriousness of the situation in the cities.

In recent years, there has been an increasing concentration of low-income families in the major cities where they constitute a larger proportion of the population than they do nationally. Such changes result in heavy demands on public health services. For example, in Baltimore registration at prenatal clinics rose 133 percent in the decade between 1950 and 1960, and in well-baby clinics, 59 percent.[5]

Other cities are having similar experiences. For example, in the District of Columbia, it has been found that only 40 percent of the births to women residents are attended by physicians as private patients.[6] In New York City, only 60 percent of the city's residents giving birth are private patients. Thirty percent of all infants in the city receive their health supervision at the health department's well-baby clinics; in one district, the proportion is over 80 percent.[7] In Dallas, a recent study revealed that 36 percent of the maternity patients make partial or no payment.[8]

In seeking medical care, these low-income families are straining the resources of the communities in which they live. For the most part, they receive outpatient and hospital care in the tax-supported hospitals as voluntary hospitals increasingly require payment by or in behalf of each patient admitted. The result has been a great overcrowding of many city tax-supported hospitals, leading, along with understaffing, to conditions which are incompatible with a decent quality of care.

To accommodate such large numbers, some hospitals discharge maternity patients 24 to 72 hours after delivery. In Chicago the Cook County Hospital delivered almost 20,000 patients in 1962, and as a result of overcrowding is in danger of losing its accreditation. Yet the Cook County Hospital is required by law to accept all eligible patients.

Michael Reese Hospital, the only voluntary hospital in Chicago which takes large numbers of indigent maternity patients, periodically closes intake in its prenatal and other clinics because of the excessive caseload. The Cook County Hospital cannot do this, and consequently clinic patients often have to wait all day to be seen, and sometimes have to return the next day. Demands on well-baby clinics are similarly high, yet in Chicago the number of well-baby clinics operated by the health department was cut down from 98 in 1945 to 49 in 1960. A 26-percent decrease also took place in well-baby clinics sponsored by the Infant Welfare Society, a voluntary organization.[9]

Dr. John D. Thompson, professor and chairman, department of obstetrics and gynecology at Emory University School of Medicine, Atlanta (Ga.), in an unpublished report has aptly described the situation in many city hospitals:

> On the obstetrical services of these large charity hospitals, the massiveness of the prenatal clinics is unbelievable. It is simply not possible to give adequate prenatal care under these circumstances of too many patients and too few doctors, nurses, and social workers, and inadequate facilities. Each patient is seen by a doctor for only a very few minutes. The doctor does not get to know the patient and the patient does not get to know the doctor. Many important aspects of prenatal care have to be omitted. In a recent study in our hospital [Grady Memorial], it was found that 23 percent of all patients delivered came to the hospital first when they were in labor, having had no prenatal care. Only 11 percent of all delivered patients came for prenatal care in the first trimester of their pregnancy. This is in marked contrast to the experience in private practice. Ninety to 95 percent of the patients delivered by private obstetricians had had prenatal care beginning in the first trimester. I point to our hospital only as an example of a situation I know to exist in almost all of the large charity hospitals in this country.

In support of Dr. Thompson's statement are figures which show that in Dallas, approximately one-third of low-income obstetrical patients had received no prenatal care;[8] at the Los Angeles County Hospital in 1958 the proportion was 20 percent;[10] at the D.C. General Hospital in Washington, D.C., 45 percent.

Studies of why women have failed to receive prenatal care [8,11] cite a number of deterring factors important among which are: transportation difficulties and expense caused by the centralization of clinics; unrealistic financial and residential eligibility requirements for clinic care; and dissatisfaction with the long waiting hours and impersonal attitudes encountered in the clinics.

The relationship between the lack of prenatal care and prematurity has been well-established.

In Philadelphia [12] in 1961, in a district where only 1 percent of the maternity patients had had poor or no prenatal care, the prematurity rate was 7.9 percent. In another district where 36 percent of the women had had poor or no prenatal care, the prematurity rate was 15.7 percent.

A study done in New York City in 1957 found that among 70,952 women with adequate prenatal care, the prematurity rate was 7.8 percent. Among 8,683 women with no prenatal care, the prematurity rate was 20.3 percent.[13]

In Chicago in 1961, the prematurity rate in the highest income census tracts was 7.5 percent; in the lowest, it was 14 percent.[14] Comparable figures in New York are 6.2 percent and 16.5 percent.[15]

Because prematurity, as defined by birth weight, occurs more frequently among nonwhite groups, the possibility of a relationship of this increased frequency to genetic or racial factors is sometimes expressed. Studies of rates of prematurity among Negro private patients do not bear this out. The study of Negro maternity patients in a prepaid group practice medical care plan in New York (Health Insurance Plan) shows that 8.8 percent had premature infants.[16] While higher than the white rate of 5.5, it is close to the national average and far below the rates quoted here of women giving birth in unfavorable circumstances.

Roads to Improvement

The recent amendments to the Social Security Act related to maternal and child health services hold out great promise for attacking these problems more effectively. They may make it possible for State and local health departments to:

- Increase the number of prenatal and postnatal clinics.
- Bring such clinics close to the population served.
- Establish special clinics for some patients with complications of pregnancy (where more time by obstetricians, nurses, social workers, nutritionists, and others can be provided).
- Pay for hospital care not only for the delivery but also during the prenatal period as needed.
- Relieve overcrowding in tax-supported hospitals by paying for care of indigent patients in voluntary hospitals.
- Pay for hospital care of premature infants and other infants needing special attention.

First, we must seek out the causes of mental illness and of mental retardation and eradicate them. Here, more than in any other area, "an ounce of prevention is worth more than a pound of cure." For prevention is far more desirable for all concerned. . . .

Second, we must strengthen the underlying resources of knowledge and, above all, of skilled manpower which are necessary to mount and sustain our attack on mental disability for many years to come. . . .

Third, we must strengthen and improve the programs and facilities serving the mentally ill and the mentally retarded. The emphasis should be upon timely and intensive diagnosis, treatment, training, and rehabilitation. . . .

. . . For too long the shabby treatment of the many millions of the mentally disabled in custodial institutions and many millions more now in communities needing help has been justified on grounds of inadequate funds, further studies, and future promises. We can procrastinate no more. . . .

JOHN F. KENNEDY, in his message to Congress on mental illness and mental retardation, February 5, 1963.

- Provide medical consultation services for patients with complicated conditions.

Under the special projects provision of the amendments, the use of project grants rather than the formulae apportionment system used in the other programs means that aid can be channeled on request to places of greatest need. Large cities as well as rural areas may be included.

The expansion of the maternal and child health program may also make it possible for explorations to be made in methods of providing comprehensive health care, as recommended by the report of the President's Panel on Mental Retardation. The report, for example, recommended that the Children's Bureau support some demonstration programs in the provision of long-range child health supervision among poorly motivated families. This would have pertinence for children who become retarded because of the lack of stimulation in their environment. One way of providing continuity in care suggested by the Panel was the establishment of maternal and child health centers in which the professional staff would divide their time between the centers and the hospitals.

Additional explorations might also be made into ways of making the most effective use of hospital and clinic staff in face of the serious shortages of professional personnel.

Most important perhaps will be the ability a stepped up program will give the States to keep pace in their ongoing maternal and child health services with increases in the population and advances in medical knowledge. The result will be earlier detection of conditions in mothers and children which lead to mental retardation as well as earlier case finding of retarded children themselves.

Secondary Prevention

A major part of these stepped up maternal and child health services is envisioned as being an expansion of diagnostic and treatment services for mentally retarded children. Today 77 special clinics operating as a part of maternal and child health programs are providing diagnostic evaluations of mentally retarded children, interpretations to their families, and followup help with child care and management. Such services are important tools in secondary prevention, for through the parents they help the child to make the most of his capacities. In 1962 these 77 clinics served 20,000 children, most of them of preschool age, in 46 States. But this has not been enough. Waiting lists at all these clinics are long, and for many families with retarded children the nearest clinic is too far away to help. Even before passage of the amendments, 24 States had asked for additional Federal funds to expand existing clinics so that they might extend their services to more families.

This goal will soon become possible. It will also become possible to develop new clinics so that eventually every State will have a network of clinical programs. Another goal is to help established clinic programs extend the types of services they offer to include genetic counseling and chromosome analysis for couples who are worried about the possibilities of having a defective child.

Other goals are to expand the professional training programs carried on in such clinics to pediatricians, clinical psychologists, and other professional personnel, and to train auxiliary workers, such as recreational and occupational therapists, day-care teachers, and institutional workers in ways of working more effectively with the retarded.

Demonstrations may also be made through these clinics of ways in which intensive pediatric care begun early in life can prevent the development of secondary handicaps in retarded children.

Children who carry the double burden of physical and mental handicaps have been the least likely to get the services they need. State crippled children's programs have not been able to keep pace with the rise in demand for their services—due largely to the rise in child population—nor with the rising costs of medical and hospital services. Hospital costs, which comprise 40 percent of the cost of crippled children's services, rose from an average daily cost per patient of $16.77 in 1951 to $34.98 in 1961, and are continuing to increase at the rate of almost 7 percent a year. Nevertheless, during 1962 State crippled children's agencies, with $25 million in Federal funds and $54 million in State and local funds, provided medical care and other corrective services to 384,500 children with such conditions as congenital heart disease, cerebral palsy, rheumatic heart disease, hearing impairment, epilepsy, and orthopedic problems.

In some States the proportion of children served in these programs who had mental as well as physical handicaps was as high as 17 percent. In many States, however, the crippled children's agencies, faced with waiting lists and limited funds, pass over severely retarded children in making selections of who is to be served. Sixteen States make no attempt to provide crippled children's services to children in institutions for the retarded, and 24 other States provide only very limited services to such children.

A major goal in the expansion of crippled children's services, as authorized under the new amendments, is to help the States extend their crippled children's services to retarded children both in and outside of institutions. Another goal is the establishment of clinical centers for children with multiple handicaps, including retardation. Only a few States now have such clinics. Their obvious advantage is that they make it possible for the child to be evaluated as a whole, with the interrelationships of his physical and mental handicaps taken into account in his management and treatment. Another advantage is the reduction of strain both on parents and child when they no longer have to travel from clinic to clinic to secure the kind of care the child needs.

Correcting a mentally retarded child's physical handicaps is an important aspect of secondary prevention, for when a physical burden is lifted or lightened the emotional burden which aggravates retardation[1] is also alleviated.

Any child who has a handicap of any kind ought to get the professional attention and care he needs. Unfortunately, some crippled children's agencies have been able to offer service only in regard to a few specific handicapping conditions. Therefore, the priority goal in looking toward the expansion of these services is to bring about a broadening of the term "crippling" so that services may be provided to children handicapped by any form of disability or long-term illness, including mental retardation. Other goals are the development of inpatient and outpatient facilities for adolescents and an increase in demonstration and specialized training projects.

Research

New scientific knowledge about the causes of mental retardation—the foundation of preventive efforts—must come from basic research into the biological and psychological processes of human growth and development. Such research is now being carried on in many parts of the country, much of it under the auspices of the National Institutes of Health. But unless there is also research into the application of knowledge through services, preventive efforts may prove ineffective.

Until passage of the recent amendments to the Social Security Act, the Children's Bureau had no specific authority to make grants for research related to maternal and child health services and crippled children's services. It did, however, support a few studies, such as the trials of the Guthrie blood-drop test for detecting phenylketonuria, an inborn error of metabolism responsible for serious retardation in untreated children. (See CHILDREN, September–October 1963, page 201.) However, under the new research authorization for making grants to public and other nonprofit agencies and universities, other questions important to the evaluation and improvement of services can be sought in a systematic fashion. Among those specifically concerned with services to retarded children are:

- What methods of assessing a mentally retarded child's potential for progress can be developed which would not require a full diagnostic team and could be applicable in the physician's office?
- What are the costs and comparative effectiveness

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of providing clinical services to mentally retarded children through various settings—hospitals, local health departments, traveling clinics, and so forth?

- What is the availability of services for blind retarded children, and what kinds of services do they require?

Other researchable questions important to the improvement of maternal and child health services and crippled children's services are:

- How can school health services be improved, especially in relation to followup on recommendations for medical care?
- What are the problems which low-income families experience in obtaining medical care?
- What experimental approaches can be developed to assist physicians in the provision of medical care?
- What are the indices for determining the quality of hospital care for mothers and newborn infants?
- How many children with operable congenital heart conditions are not receiving care, and why?

A Rounded Approach

Rounding out this broadened program of services to mother and children, with its heavy accent on prevention of both mental and physical disabilities, is the authorization for project grants to the States for planning action to combat mental retardation. The major goals of this provision are to engender interest and support for services within States and communities and to foster the development and coordination of the mental retardation aspects of programs of education, rehabilitation, welfare, employment, health, recreation, and legal protection of the mentally retarded.

The importance of coordinated planning was strongly stressed in the report of the President's Panel on Mental Retardation, which specifically recommended that such grants be authorized. Behind the recommendation was the finding that resources for the mentally retarded vary widely from State to State and among cities and counties within the States. Stimulation of community interest and coordinated action would be necessary, the report indicated, for filling those gaps.

Mankind is a long way from the millenium of eliminating the tragic problem of mental retardation. In the new amendments to the Social Security Act, however, vast opportunities have been opened for preventing its occurrence in many families and for alleviating the suffering it causes in many others.

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[1] U.S. Department of Health, Education, and Welfare, The President's Panel on Mental Retardation: A proposed program for national action to combat mental retardation; a report to the President. October 1962. 1963.

[2] Eliot, Martha M.: The children's titles in the Social Security Act. III. Origins and development of the health services. *Children*, July–August 1960.

[3] Lesser, Arthur J.: The children's titles in the Social Security Act. IV. Health services—accomplishments and outlook. *Children*, July–August 1960.

[4] Harrington, M.: The other American. Macmillan Co., New York. 1963.

[5] Tayback, M.; Wallace, H.: Urban economics and public health. *Public Health Reports*, October 1962.

[6] Oppenheimer, E.: Population changes and perinatal mortality. *American Journal of Public Health*, February 1961.

[7] Piore, N.: The scope of tax expenditures for urban medical care. *Baltimore Health News*, June–July 1962.

[8] McPhail, F.: Review and evaluation of maternity services. Dallas County (Texas) Youth Study. 1962.

[9] May, Charles D. (ed.): Medical responsibilities for the displaced child; report of the 43d Ross Conference on Pediatric Research. Ross Laboratories, Columbus, Ohio. 1963.

[10] California Department of Public Health: *California's Health*, July 1, 1960.

[11] Monahan, Howard B.; Spencer, Esther C.: Deterrents to prenatal care. *Children*, May–June 1962.

[12] Philadelphia Department of Public Health: Annual statistical report, 1961.

[13] Silverman, William A.: Premature infants. Hoeber, Inc., New York. 1961.

[14] Chicago Board of Health: Report from Board of Health. 1961.

[15] New York City Department of Health: Bureau of Records and Statistics, 1961.

[16] Shapiro, S., et al.: Further observations on prematurity and perinatal mortality in a general population and in the population of a prepaid group practice medical care plan. *American Journal of Public Health*, September 1960.

> **For an entire generation we have been surrounded by violence. The media of mass communication glorify that violence daily. Human life and personality have been cheapened. How then should we blame our youth if they discard our value system?**
>
> ***Robert H. MacRae to the 1960 White House Conference on Children and Youth.***

SOME CHALLENGES TO THE AMERICAN FAMILY

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SEVERAL important changes in our civilization have created new demands on human resources which are not adequately met now. They open new vistas for family functioning.

For example, one of the most cherished values of American life is independence. The family and other social institutions, such as educational and medical services, are supposed to cater to the dependency of children only with a view of helping them to achieve independence. Under the impact of this orientation we have failed to notice that the length of time required for training to cope with adult life, the labor-saving devices of an automated society, and the earlier and earlier retirement ages coupled with the life-prolonging advances of medicine have made dependency the normal living condition for roughly two-thirds of the human life span. This implies that even more important than services to help people achieve independence are efforts to help them learn how to live with dependency, their own dependency and the dependency of their associates. In this reorientation the family may be able to play an important role.

The family is a storehouse of experience for living with the dependency of childhood. It may well be able to adapt and transfer this experience to the problems of living with the dependency of advancing years. In an affluent society this presents more psychological than economic problems. It requires people to find more pleasure in one another in the present rather than anticipation of pleasure in one another in the future. It requires the aging and the infirm to develop an ability to find satisfaction in living so that their condition of dependency does not become a threat to younger and independent people. The aged complain about not being permitted to be useful to others. Actually their usefulness lies in their own hands. It lies in *not* stimulating fear of the future in their adult sons and daughters and in other younger associates. Older family members have an important job to perform to make old age seem sufficiently desirable to help people look forward to it with equanimity rather than with fear.

This one aspect of family life—the increasing span of human dependency—represents enough challenge to interpersonal competence between the generations to occupy family ingenuity and interactional experimentation for the next half century. By implication it suggests changes in child rearing. Today in our middle-class pattern of family life, parents provide the physical and emotional nurture which children need for maturation and development, but there is little provision in our modern family make-up for return services to be rendered to the parents by the children. One cannot bring up children without demands for reciprocity and then expect reciprocity from them when they are grown and have taken on other responsibilities.

Problems of Affluence

In an affluent society the concerns of many people shift from acquisitiveness to conservation. People want to maintain what they have achieved and to be relieved of the problem of acquiring more. The result is a defensive stance toward life in many people. He who has possessions is worried. The more he gets the less hope for material improvement is left to him. He becomes ridden by feelings of anxiety, hopelessness, and loss of purpose. This implies a need for patterns of family living which will

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Condensed from a paper presented at a meeting of the Washington Center for Metropolitan Studies.

strengthen children's inner resources and idealistic concern rather than egotistical frames of reference and external achievement.

The problem is aggravated by the fact that we still recall and still profess the social ideals of an individually aggressive and conquering stance toward living. People who have attained status and the concomitant rewards feel that they should improve further, even after there is little hope of being able to do so. In fact for large numbers in our population the essential reorientation needs to change toward letting ideals match realities and becoming concerned with maintenance in the place of acquisition. This is a skill which will also have to be learned in family life.

Families that move from house to house and from neighborhood to neighborhood, without being forced to do so by long-range plans, are apt to be singularly lacking in maintenance skills. They are tempted to mine their properties rather than to preserve them. From the exploiting of property to the exploiting of human relations there is no great distance.

Learning To Give

A society in which there is much to conserve cannot afford a mode of family life in which exploitative attitudes toward people and things are prevalent. This, however, is frequently the case in family life today, with varying degrees of intensity. Psychiatrists and social workers have become increasingly concerned with the appearance of "character disorders" in their patients and clients. By "character disorder" they mean such a strong preoccupation with "getting" from other people that the possibility of giving is completely excluded. Persons whose interpersonal attitudes are dominated by this tendency to a pathological degree are, of course, in the minority, but the cultural climate frequently fostered and even expressed in child rearing practices suggests that in lesser degrees such attitudes are widespread.

This presents another challenge to family life. Young marriage partners and their children may have to learn that the value of giving is not only higher than the value of taking but also in the long run more efficient in human relationships. In this connection they will also have to learn that giving and taking, although essentially interconnected, can never be balanced in human relationships. There is no accounting in family life.

Furthermore, the family in the next 50 years may have to develop a greater ability and readiness for decision-making than were required of families in the past. When a family had to operate in a society of scarcity, decision-making was easy, if not automatic, because the occasions for decision-making were repetitive and the solutions known, and prescribed. In an affluent society many alternatives for achieving satisfactions suggest themselves. But human capacities to absorb satisfactions remain limited. In consequence more decisions among alternatives, fancied and real, have to be made. Therefore there are more occasions for regret and immobilization by conflicting alternatives. Thus the family will also have to develop in its membership an ability to live with the consequences of their decisions.

Most important, the family will have to teach its members to accept the fact that there are no definitive solutions. We all have tendencies to live as if we believed in ultimate solutions and expected definitive and lasting satisfactions from our decisions. We engage in war to end all wars, we marry to find permanent happiness, and we rear children with the expectation that if we do a good job they will be happy no matter what happens to them. In these days of rapid social change, the longer we live the less likely are our expectations to remain valid. The family will have to teach its members that decisions have to be made no matter what doubts exist, that even the soundest decision may be invalidated by the course of time, and that striving means retaining coping capacity rather than making coping unnecessary.

The Therapeutic Family

Finally, the family of the future faces another challenge. The advances of organic medicine, dynamically oriented psychiatry, and social work have created in many people the idea that when the family fails in any way a professional helper will be available to remedy the situation. In this frame of reference one family member, two family members, or at best the total family are seen as the patient, as an individual or an organization experiencing needfulness rather than strength. As our society creates an increasing understanding of mental health and of the part of the patient in the helping process, it might well come to viewing the family which has difficulties as a potentially therapeutic organization as well as a suffering organization. This therapeutic organization will, of course, include a professional helper; but it will turn the family members into cotherapists, and in that way the family as a therapeutic organization may be a stepping stone to a therapeutic society.

Some observations of . . .

ADOLESCENT DELINQUENT GIRLS

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FOR *in its innermost depths youth is lonelier than old age.*[1]

Thus wrote 15-year-old Anne Frank in her wartime hiding place. Now here are the words of some teenage girls of today—Caucasian, Negro, and Indian—in Minnesota's correctional institutions:

> You don't talk much with parents. Perhaps people never did, but today you expect it more. You should be able to.
>
> Have you ever been lonely? When I was in the foster home I could not see my sister or my brother. I felt so lonely. I wanted to hang around other kids.
>
> People don't understand. Adults forget. I was 12 years old when I got into trouble. . . . I ran away 10 times; I was homesick. Nothing keeps me when I am homesick. . . .

You will recognize easily the same sentiments you find in any other teenager. They show mostly a feeling of loneliness and of not being understood, and of wishing to be heard. Over the past year I interviewed more than a hundred delinquent girls in institutions. The interviews usually lasted an hour or more and were conducted as part of a study of the adolescent girl in conflict. The girls were told that none of the material would be incorporated into their records. During this same time period, I also conducted a series of intensive social group work sessions with two groups of delinquent girls. The material presented here is based on both the interviews and the group sessions.

One of the major motivations for my study was the paucity of knowledge about adolescent girls, especially about those who have come into serious conflict with society.

Cultural expectations are especially confusing for girls. While the emancipation of women has been proceeding rapidly, the traditional double standard for men's and women's behavior and position in society continues to have meaning for family relations and child rearing. For example, while the girl is educated to choose her place in the working life of the community and is encouraged to become a participating citizen, she frequently encounters not only job discrimination but also rejection of her intellect. Femininity and intelligent self-determination are regarded as contradictions.

While no human being grows up without having to resolve some value conflicts, the conflict related to the basic role of women cuts deeply into the personality of every adolescent girl. For some girls this conflict, aggravated by other stresses, leads to inner turmoil, withdrawal into emotional or mental illness, or delinquency.

The complex problems of delinquent adolescent girls are often misunderstood. As a result institutions often deal with them in a rather rigid, unimaginative fashion. While the prevailing attitude toward delinquent boys is often "boys will be boys," the attitude toward delinquent girls is usually one of deep resentment, especially when they have acted out sexually. The girls themselves are usually full of inner helplessness or hostility which they are unable

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A common subject of discussion in mid-century America is assigning the blame for our mounting juvenile delinquency—to parents, schools, courts, communities, and others, including the children themselves. There is no single answer—and no single cause or cure. But surely the place to begin is the malady which underlies so much of youthful frustration, rebellion, and idleness; and that malady is a lack of opportunity.

JOHN F. KENNEDY, in his message to Congress on our Nation's youth, February 14, 1963.

to express or to channel in any constructive way.

Undoubtedly, delinquent boys and delinquent girls have many similar problems. They are adolescent with the familiar inner turmoil of this stage of development. In many instances, this has been aggravated by the impact of economic blight, of racial discrimination, of difficult family relationships, of poor housing, and of personal problems. Yet, girls have problems specific to their sex, and only if we become aware of these can we be helpful to delinquent girls. These problems lie partially in the girl's biological makeup and partially in the cultural lag.

Relationship to Peers

While all adolescents are deeply emotional, girls seem to be especially hungry for significant relationships. The delinquent girls I know feel exceedingly lonely and yearn for friends, but they have no camaraderie. They express this yearning by saying that they have no friends or that youngsters of their own age do not interest them. The most frequent reason they give for this is: "I am more mature; I grew up fast." Most of these girls regard their contemporaries as childish. Another reason they give for not making friends is school failure.

Two other reasons frequently given to explain loneliness relate to cultural differences and to high mobility. Some Negro girls, for instance, have said that they got along all right with others when they were in grade school but could find no friends when they entered predominantly white high schools. Other girls have said they got along fine as long as their parents stayed in the working-class neighborhoods where they grew up. Trouble started when the family moved to the suburbs where "the kids were uppity," and "I couldn't compete with the way they dressed." Popularity has a high value among adolescent girls, especially those excessively dependent on peer acceptance for a feeling of self-worth.

The void left by lack of friends is usually filled through a love relationship or through the "crowd." The crowd consists of other girls who feel rejected by the "good" people and who may have also been in trouble. The girls say that they can feel comfortable with the crowd and do not have to pretend. The crowd, however, does not have the cohesiveness of a gang. Few girls, at least in Minnesota, belong directly to gangs. A girl's gang affiliation usually is her friendship with a specific boy.

Sometimes a girl tries to persuade her boy friend to discontinue certain delinquent activities; on the other hand, the girl is sometimes the stimulus for boys' delinquent acts. Said one girl:

> . . . My friend is in prison. He broke into a supermarket. I don't think it's right. I tried to persuade him not to do it, but he won't listen to me. Boys don't listen to girls. Why do I think it's wrong? He just gets nothing out of it. He just gets caught.

And on the other side of the coin:

> . . . They fought about me. I just sat on the stairs one day. Eric passed by. He said, "I'll pull you down the stairs." I told John about that. Then they fought. They always fight over girls.

In an effort to meet her deep need for friendship, the girl gets involved early in highly emotional, introspective, and romantic relationships. Her image of these relationships contains little reality. Every boy she relates to she sees as the "one and only," the Prince Charming. This is so even when she knows that the boy is having relations with other girls.

While frequently a sexual relationship is something casual to a boy, to most girls such a relationship has deep meaning. Even the promiscuous girl—with rare exceptions—does not really want promiscuity. She does not consider it immoral to have sexual relations as long as these are connected with affection. Only when no affection is involved is sexual behavior considered "wrong," "bad," or "dirty."

Girls deeply resent the "double standard." They complain bitterly that they are punished for relations about which boys may boast. The double standard has existed since time immemorial and there must always have been girls and women who resented it; yet, in a century when the girl expects to be treated as an equal, her resentment is undoubtedly more pronounced.

All adolescent girls show strong emotional attachment to other girls of about their own age or older. The delinquent girl, isolated from the community, often develops such attachments in a pronounced form. The dynamics of this may partly be related to the basic identification problem of the girl, which is different from that of the boy, and partly to individual problems. To elaborate:

1. **The Identification Problem.** Infants are closely attached to a female person—the mother. The boy establishes his identity as a male through experiencing an early love relationship with his mother and then separating himself from her and identifying himself with the father. The girl, too, as an infant is closest to the mother; but she establishes her identity as a woman by an early love relationship with the father and then identifying herself with the mother. The complicated part of this process is that, like the boy, the girl must loosen her bonds with the person she has been closest to as an infant but, unlike the boy, she cannot move to another person for identification. This accounts for the adolescent girl's highly ambivalent feelings, in relation to her mother and other females.

2. **Additional Individual Problems.** The girl's identification process is greatly complicated when there is no father in the home or when the father is a brutal one. Many delinquent girls have had no way of living through the healthy step of loving their fathers; they therefore have remained attached to the female as a love object, although with great ambivalence. Girls who have been raped by their fathers (and they are not rare among delinquent girls) find relationships with men either threatening or disgusting and also turn to other girls for the fulfillment of their emotional need for love.

Frequently, the only way a girl can find a feeling of self-worth is through having a boy friend. This is supported by the dominant culture. Yet, there are many girls who see themselves as ugly and undesirable; therefore, they do not dare compete with others for boys. A love relationship with a girl thus becomes a welcome substitute:

> Some girls are spoiled and get a lot from their parents. . . . My parents wouldn't send me a piece. Nothing. Now I have some things because I "go with girls." That's one way of getting them. But I think that's only *one* reason why girls go with girls here. Maybe it's also because there are no boys around, but I don't think that's the main reason. I think it's because a girl is lonely, and that way she feels accepted. And there are many girls like myself, who don't think that a man will ever look at her, because they are so ugly. . . . So it makes you feel good that somebody thinks you are something. If a man laughs at you, it's terrible, so you are afraid of meeting men, and you go with girls.
>
> It's parents who make you feel low. My mother has always said that I am ugly, and then, if you are on the outside and you aren't pretty, kids laugh at you and tease and that makes you worse. You hate the world. If finally somebody loves you, and if it is a girl, you are happy. . . .

A girl's tendency to homosexual relationships is often intensified by the fact that such relationships seem "safer" since they do not produce an unwanted child. Some girls regard them as "pure," since they are not connected with males, whom they consider as ugly and brutal. Such relationships are idealized:

> I have a girl, a simply wonderful girl . . . I need her . . . I love her . . . I feel better toward all people. I feel satisfied. Now I have somebody to care for. Now I have somebody I want to make happy and somebody I will work hard for . . .

Certainly these tendencies were intensified in many of the girls I saw by the fact that they were in institutions restricted to females and so were deprived of male companionship.

Relationships to Adults

The girls I interviewed showed very little confidence in adults. In fact, it seemed as though the bridges between the two generations were broken. Adolescents normally relate more freely to their contemporaries than to adults and rebel against—or, at least, question—adult authority. Yet there is usually some communication between the generations. But most of these girls could not name a single adult in whom they could confide.

Nevertheless, one of the major resentments I found in the girls was against the person who places all the blame on the youngster's parents. Many of these girls seem to regard parents as just one part of a hostile, strange, adult world. They especially resent adults for being "phonies," saying that adults preach one thing and do another. One girl, for instance, reports that her mother calls her a "slut" when she goes out with boys, but that the mother does exactly the same thing. Many girls talk with bitterness about being prosecuted as prostitutes, pointing out that the "good citizen" has frequently sought them out.

Many girls, of both major races, express strong resentment over prevalent adult attitudes toward race. They have been told that "all men are created equal," yet they are constantly confronted by adults' prejudice toward others. They report that even social workers sometimes reveal inner prejudice; for example, when they make girls feel that, while prostitution in general is bad, for a white girl to be intimate with a Negro man is worse. Such attitudes strengthen the girls' feeling that adult hypocrisy justifies rebellion against adult society in general. Girls report experiencing racial prejudice in almost all adults they know—their own parents, social service agents, probation staff, and the staff of correctional and parole institutions.

It is a mistake, however, to regard the delinquent girl only as a rebellious person. I found evidence of great dependency needs which seemed almost completely unfulfilled. Girls were yearning for an adult who would protect them.

> **I am afraid when I lie there in the evening. I am afraid of the dark . . . I am just afraid. I think if I had had a mother, things would have been different . . .**

Values and Goals

Many sociological studies suggest that there are great differences between the values and goals of middle-class and lower-class populations. My own impression is that the basic goals of the girls I studied were not much different than those of other women. The majority of these girls would probably be classified in the lower socioeconomic grouping. Yet they expressed the same goals as are held by middle-class women: wanting to have a good home, a nice family, and enough money to travel and to raise children. They also showed the ambivalence toward the woman's role characteristic of the dominant culture.

The distinction between classes as exhibited by these girls does not seem to lie in basic goals, but in the way the girls try to realize their goals and in their conceptions of *morality* as distinguished from *morals*. The basic moral value of our democratic society—concern for other people—was generally accepted. The *specific middle-class morality*, with its high emphasis on thrift and delayed gratification of sexual drives, was not always accepted.

The delinquent girl's role ambivalence shows strongly in her attitudes toward school and work. While tradition clearly indicates that a boy must make a living through employment, this is not yet completely accepted as an expectation for girls, either by the girl herself or the society surrounding her. Many of the girls I interviewed look forward to marriage as a way out of having to work; they regard the securing of employment as only a transitory obligation. Many of these girls resent the fact that boys can make better wages at unskilled labor than they can, even in the tightening labor market:

> **Boys get jobs much easier. If a boy doesn't want to go to school or finish school, he can find a job. They find those jobs where one needs muscle. Girls never get the good jobs and whatever jobs girls get they always get less money. There are no chances for girls.**

Society in general has a stereotyped picture of what a girl should do, including the type of job she can carry. In the interviews, some of the girls hesitatingly admitted a preference for so-called "male" occupations such as truck driver or mechanic. They felt frustrated by the narrowness of choices.

Most of the delinquent girls I have known have exhibited a warmth of feeling toward anybody who is helpless. They want to be helpful to others. Again, there seems to be little outlet for this in occupational choice, because jobs with old people, children, or animals either require long professional training or pay extremely low wages.

Because of society's general ambivalence regarding the kind of work women can do, school and vocational training have comparatively low value in the eyes of most of these girls. However, the girls show a high interest in art, especially painting. This is logical because of the nonverbal character of painting and the freedom of expression it allows.

The girls' attitudes toward property show the great impact of anonymity in a mass society. Practically every girl who had violated property rights through stealing said that she had no sense of guilt about taking things from a large corporation or a department store. She expressed regret and guilt only when she had stolen from an individual. Such an absence of guilt in relation to the anonymous corporation is closely related to the delinquent girl's attitude toward authority. Unfortunately many of these girls have met authority only in an anonymous form—only the "law" or "society" has imposed standards for behavior and not a particular person who has continued meaning in her life.

Interest in community life and public events is exceedingly low among delinquent girls. They do not see themselves as contributing members in a democratic society. When I have asked questions about public policy the girls have usually commented that they are not very much interested in the subject or that one talks about such things only in school. Social problems were of concern only when the girl saw herself personally involved, as with poverty, racial discrimination, or a war scare as at the time of the Cuban crisis. In such instances the girl saw herself as a victim, not as somebody who actually could do something about the situation. Girls traditionally are expected to focus on person-to-person relationships and not on political problems. Their response to impersonal forces is therefore intensely erratic and hostile.

The delinquent girl's low self-esteem is her most outstanding characteristic. The poem on this page reflects this.

Consequences for Treatment

Treatment of delinquent adolescents needs much reform, based on knowledge of individuals and their group relations, resistance to the ever recurring "woodshed" approaches, and a clear understanding that one cannot treat delinquency, but only each boy or girl as a unique and an important personality. Yet, our knowledge of adolescence in general and of the special needs and reactions of girls, as described here, leads to some general conclusions about the treatment needs of delinquent girls:

1. **Understanding, Accepting Personnel.** Change in people can be achieved only through a positive helping relationship. This means that personnel who work with delinquent girls should be warm, generous human beings who have worked through their own sexual conflicts and who can accept the confusion of adolescents and cultural standards different from their own. They should be able to present clear-cut values without preaching and moralizing. And they should have no inner reservations about accepting women as full members in society, with varying roles which are equally valuable: wife, mother, worker, and citizen.

2. **A Variety of Treatment Facilities.** Girls tend to be especially individualistic and unsuited for regimentation. Living with large numbers of regimented people is not only difficult but often destructive to them, driving some into withdrawal or illicit (often Lesbian) love relations. Alternatives to mass institutions are: (1) comparatively ***small institutions*** with enough subunits to offer individualization and opportunities for privacy; (2) ***group homes*** for approximately 6 to 8 girls with well-trained and very accepting adults in charge; (3) ***foster homes.***

Group homes seem to be most appropriate for adolescent delinquent girls. Most adolescent girls are struggling for independence and do not want to move into too close a relationship with a parent substitute. They want to live with other girls in a place where they can have activities and meet boys and where there are adults in whom they can confide but who do not pressure them into an intimate relationship. Some delinquent girls, however, have adjusted well to foster homes.[2]

If institutions are used alertness to the quality of the group living situation is exceedingly important, for institutional cottages can easily become small replicas of congregate institutions. Only a relaxed atmosphere, in which the dignity of the individual is recognized, can prevent the further deflation of the delinquent girl's already low self-esteem. She needs to feel accepted regardless of race or creed. Like any other adolescent girl the delinquent girl also needs an opportunity to meet boys; and she needs outlets for her adventuresome spirit. These needs can be met through an imaginative program. A rich fare of creative arts seems to be especially helpful.

3. **Treatment Methods.** The adolescent girl needs desperately to work through her relationships with adults, but often she cannot do this when confronted alone by someone in authority. She wants to talk, and she talks easily and readily with other girls. The ***group work method*** provides her with the opportunity to talk with other girls in the presence of a helping adult who knows how to individualize the members of a group. It gives her an opportunity to learn to relate closely to others as a friend—not just in a love relationship. It helps her to discuss problems openly, yet feel that someone is there to protect her both from herself and from others. Such a

THE DELINQUENT GIRL'S SELF-IMAGE

By an Institutionalized 17-Year-Old Girl

The broken and withered limb
Struggles, grasping, fighting to live
And doing so destroys the tree,
Its roots and all the blossoms it has to give.

I, like that bent and broken limb
Am unable to mend my broken ways,
But sucking, drawing, hanging on
Like a parasite to that which is pure and
good.

Eventually that, too, will be broken
And without joy or blossom.
Even as the limb fights to survive
In doing so it may destroy that which is
good!
Shall I let go?

method is especially effective when provided along with *individual treatment.*

Here is how some members of a group regarded a group work experience:

Ginny: It was good to hear what others feel about things. If they think one way and I feel the same, you know, there has got to be something in it that's right. It has helped me not to feel so odd. . . . I have always said, "Well, I got to understand myself a lot better." But before being in the group, I didn't understand really deep down.

Sue: It helps to know that you are not the only one that thinks this or that. You sometimes feel . . . how come I have to be like this and everybody else is different?

Ann: You get something out of your system. Alone, you can *think* things, but if you *say* them it is better. Often I didn't know I felt that way, until I said it and others listened.

Ginny: Sometimes I wondered whether *I* really said that. I didn't know I felt that strongly about things, but I found out how I felt.

A girl needs "not to feel so odd." In interaction with others she can achieve this.

4. **Training for Employment.** Girls need opportunities for types of employment which pay a living wage and fit their abilities and interest—a need which is not met for many girls by training for domestic work, the only job training provided in many institutions. Many girls, with appropriate training, might fit into the world of mechanics, electronics, or the vast area of semitechnical jobs in modern industry, if employers could see that appropriately trained girls *can* carry out such jobs, and the girls themselves could learn to appreciate the importance of training.

Then, too, the helping professions might make more imaginative use of the girls' desire to be helpful to people, by training them for auxiliary tasks in services plagued by staff shortages.

5. **Outlets for Idealism.** Young people cannot achieve self-respect if they cannot find meaning in their lives. They need an outlet for youth's natural idealism, lest this becomes misdirected as it did in Germany under the Nazis. Girls with a thirst for adventure and feelings about injustice may be easy prey for hate groups unless they receive more attention from constructive youth groups, neighborhood organizations, and churches. They need a spiritual outlet or a cause as much as the well-behaved, contented youngsters generally served by "character building" agencies.

6. **Friendships.** Too frequently the rules of parole or probation forbid the delinquent girl to associate with the young people she knew before her adjudication or during her institutionalization. This is an impossible expectation because of the adolescent girl's great need for friends. Living up to it may in some instances be harmful because it leaves the lonely girl feeling almost completely abandoned. One of the major aspects of life "on the outside" to come up in my group sessions was the problem of friendship. The girls seemed to despair of achieving a return to "respectable" life:

Alma: You know what's hard for a girl when she gets out. . . . It is hard to think, "Well, I'll give them up." You just can't give them up if you don't have anything to substitute with. You think they will never do you any good: "They really deep down don't care about me." But you don't have anything else.

Bea: Well, you must get somebody else.

Alma: But, don't you understand? As long as you have these others, you can't get anybody else.

Dora: I don't think there are very many really true friends. Lots of acquaintances, but not friends.

Alma: I'm not strong enough to leave them. That's right. Because I don't want to be alone. And I have to have them. . . . you can't just say I don't want you for a friend. So you just go.

Bea: I'm going to go find myself some new friends!

Alma: You can't do that.

Dora: Because it takes a long time to find friends.

Alma: You can't go halfway. You can't go one night with the right people and one night with wrong people.

Bea: That's why it's hard for a girl from up here, because you can't cut them loose. They say, "Find some new friends." How? Lock myself up in a room and say to everybody, "Goodbye, I'm not going to see you anymore," and then go out on my own into a whole new world?

Dora: Because after you sit home for awhile and you don't know anybody, then you go out . . . nobody knows you.

Alma: You either call up your girl friends who have been up here or go to them. They don't care where you're from . . . what you did. Because they're in the same place you are.

The adolescent delinquent girl cannot be helped by depriving her of her friends unless other sources of friendship are provided her.

In short, the delinquent girl is first and foremost an adolescent girl living in a society of confused and changing cultural standards. The design of any treatment plan must therefore be derived from recognition of an adolescent girl's most fundamental need: to be treated as an individual, with unique potentials, with rights, with responsibility, and with a deep need for understanding and friendship.

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[1] Frank, Anne: The diary of a young girl. Pocket Books, Inc., New York. 1953.

[2] Hunt, Elizabeth V.: Foster care for delinquent girls. *Children,* September–October 1962.

NUTRITION OF ADOLESCENTS

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THERE ARE TODAY approximately 30 million young people between 10 and 19 years old in the United States[1] and their numbers are expected to double in the next decade.[2] Concern over their nutritional status is not unwarranted. The marked physical and emotional growth experienced by the adolescent results in strains that often precipitate stress and anxiety, reflected in physiologic, psychologic, and social behavior. The nutrition of the teenager is affected as much as other aspects of his development during this crucial period. The result may be: (a) an overweight teenager; (b) an underweight teenager; or (c) a teenager whose dietary intake is unbalanced in kinds and amounts of nutrients, but whose caloric intake and weight are commensurate with his level of development.

There are two good reasons for concern about the nutritional status of our teenagers:

1. Young people in late teens are establishing habits and attitudes that will remain the rest of their lives, and may be passed on to future generations.

2. One out of every four mothers bearing a first child in the United States today is less than 20 years old. Six percent of the deaths among 18- and 19-year-old girls result from complications of pregnancy and childbirth.[3]

Conception and parenthood while the body is still in the formative stage, as it is with teenage girls, create physiological stress and adjustments in the maternal body.[4] If the dietary intake of the expectant mother was inadequate during an extended period of time prior to conception, her body must not only respond to the new requirements imposed by the growing fetus, but it must also make up for existing nutritive deficits. As a result, poorly nourished teenagers frequently are poor obstetrical risks. Their babies may be born prematurely, have congenital defects, or have inadequate nutritional stores to protect them during the first few days of extra-uterine life. Young women that are excessively overweight at the time of conception and during preganancy may also be prone to eclampsia. Studies of teenage pregnancies have indicated that the incidence of eclampsia increases significantly as weight gain during pregnancy approaches and exceeds 40 pounds.[5, 6]

Nutritional Requirements

Nutritionally, adolescence is characterized by an increased need for food to satisfy energy requirements for the rapid enlargement of organs and tissues and for the changing physiological functions which follow reorganization of hormonal levels and their interactions.

The nutritional requirements of the teenager depend on sex and the level of maturation and nutritional status of the body before adolescence. Therefore, each adolescent has individual nutritional needs. Unfortunately, there is no method available at present for accurate assessment of the dietary needs of adolescents at different developmental stages.

Detailed metabolic studies of individuals at various ages demonstrate that the amount of food intake and the specific nutrients retained depend on the individual's rate of growth and the amount of his physical activity, as well as on the composition and relative proportion of the nutrients he consumes.[7-10] An unbalanced diet lacking essential foods may be more harmful to the developing adolescent than an insufficient diet.

There is little doubt that extremely poor nutrition and dietary habits during the younger years of the life cycle affect the mature physique and lead to reduced stamina as well as lowered resistance to infection. It is also known that requirements for specific nutrients fluctuate at different age levels and that

> *Good health for all our people is a continuing goal. In a democratic society where every human life is precious, we can aspire to no less. Healthy people build a stronger nation, and make a maximum contribution to its growth and development.*
>
> *This national need calls for a national effort—an effort which involves individuals and families, States and communities, professional and voluntary groups, in every part of the country. The role of the Federal Government, although a substantial one, is essentially supportive and stimulatory. The task is one which all of us share—to improve our own health and that of generations to come.*
>
> JOHN F. KENNEDY, in his message to Congress on the health program, February 7, 1963.

metabolism in the adolescent can be quite capricious. However, present knowledge of the metabolic needs of teenagers is still fragmentary. A great deal more investigation is necessary.

However, some studies have been made which provide a basis for some general observations on the nutritional status of teenagers. For example, studies of family nutrition and research involving school groups at different ages indicate that older girls and boys have the poorest food habits and the least satisfactory nutritional status, the diet of girls tending to be less satisfactory than that of boys. It was found that only 10, 21, and 25 percent of boys and 8, 9, and 13 percent of girls in the agricultural States of Kansas, Ohio, and Iowa, respectively, consume diets that conform to the recommended dietary allowances of the National Research Council.[3, 11] Frequently, the value of the individual daily intake reported was considered by the researchers to be low in calcium, vitamin D, and vitamin A. However, in these studies the proportion of children found to have exceedingly poor diets was low.

A word of caution is necessary in relation to use of the Council's Recommended Dietary Allowances as a basis for judging the adequacy of the diets of any age group. As stated in the 1958 revision of the "Recommended Dietary Allowances"[12] wide variations among individuals exist in the margin of sufficiency above minimal requirements. These are caused by relative differences in storage capacity in the body as well as by varying individual requirements and possibly also by excessive intake of some nutrients. Thus, available information is not adequate to permit accurate determination of optimal levels of intake on an individual basis. The recommended allowances can serve only as a point of reference. Great caution must be used in applying them to adolescent boys or girls because of the marked differences in growth rates among adolescents.

Clinical examinations and nutrition surveys indicate that 19 percent of our teenagers are underweight and 30 to 35 percent are overweight.[13] Both overweight and underweight findings appear more frequently among girls than boys, and among older than younger girls. However, the diagnosis of obesity or leanness is a difficult one to make particularly for borderline cases. The extensive use of standard height-weight tables is to be discouraged since these tables do not account for differences in the relationship between lean body mass, bone, and fat. Obviously, more extensive epidemiological studies of body composition in adolescence are needed.

Teenage Eating Habits

Several reasons have been advanced to explain the poor eating habits observed among adolescents: (1) teenagers take part in many activities that keep them away from home at meal times; (2) their habits begin to be influenced more by conformity to peer groups than by their home; (3) their desire to assert independence often influences them to abandon formerly good eating habits; (4) they skip breakfast because they do not allow enough time for it; (5) in selecting snacks, they pick foods having calories derived from fats and sugars;[14] and (6) many teenagers, particularly girls, fear the word "fat" whether they are overweight or not.[15]

A girl's fear of "fat" is not difficult to understand when one realizes that during adolescence fat deposition occurs normally in the female irrespective of eating patterns. Not understanding this phenomenon the adolescent girl becomes alarmed and even frightened. Her concern is manifested by a severe cutback of food intake and the use of crash diets.

An evaluation of teenage dietary intake quickly reveals that bizarre eating patterns are frequently adopted regardless of underweight, overweight, or normal weight conditions. These patterns are a reflection of the social, economic, emotional, and cultural milieu in which the adolescent finds himself.

The young person's adjustment to this milieu, which depends on his peer acceptance, expression of independence, degree of emotional maturity, and cultural influences, determines in part the degree of deviation from the normal exhibited in his eating patterns. This is particularly true of the adolescents who do not conform physically to their peers, particularly those who are noticeably under- or overweight.

Nutritional Counseling

The main problem in nutritional counseling is to arouse teenagers to want to do something about their nutrition. An approach to this can be illustrated by the experiences of the authors during the last 4 years when operating a summer camp for overweight adolescent girls aged 12 to 18 years. The basic principles we used to strengthen motivation for weight control and to teach good nutrition can be applied, with minor variations, to correct the dietary problems of all teenagers, whether overweight or underweight.

Two important points emerged from these experiences as basic to the success of any program involving teenagers, namely: (1) acceptance of the teenager by adults for what they are and not what we would want them to be; and (2) active participation by the teenagers in the solution of their own problems. The responsibility of adults under these circumstances is to provide the teenagers with the information needed to improve their diet and thereafter to act as guides and consultants.

It is well-known that teenagers seek and require acceptance by their peers, but it is less well-known that they also seek and need this acceptance from the adults with whom they must live and work. The behavior of many teenagers toward adults would seem to belie this statement; but, in all fairness to them, it should be recognized that their rebellious behavior is sometimes precipitated by the adults themselves. Adults are prone to point up the adolescents' faults, subjecting the young people to frequent criticism without mentioning their attributes and achievements—which generally are many.

Secondly, to involve the adolescent in the solution of their problems, they must first have some basic knowledge about themselves. Adolescents are by nature very curious. They want to know what is going on around them, but, more important, are anxious about themselves, their growth and bodily changes, and feelings. Adults tend to forget that the teenager does not understand the "why's" of growth, and the "how's" of bodily functions. Since the nutrition of teenagers is so important to their growth changes and to their future as parents, there is perhaps no better way to motivate them to do something about their weight or their faulty diet than to approach the whole subject from a physiological point of view. Such a discussion must be geared to the youngsters' level of comprehension.

This has been the approach used for the past 4 years at the summer camp for overweight girls already referred to. Campers who have attained normal weight while there and maintained such thereafter comprise 40 to 50 percent of all.

The campers were organized by age into groups of 30, each group meeting with the nutritionist 2 or 3 times a week. In the discussions the four basic food groups and their nutrients were emphasized. Each nutrient was presented from the point of view of recommended amounts for ages, physiological and metabolic functions, relationship to growth, deficiency diseases, and foods in which it was found abundantly. The nutritionist explained the importance of various dietary constituents to tissues and organs and their functions, which in turn were related to the appearance of the teenager. She also discussed individual variations in rate of growth as well as the influence of heredity and environment on physique.

The campers often expressed concern about differences in body build between age mates. As a result, a great deal of time was spent discussing somatotype, body composition and differences in bone structure, fat-padding, and musculature. The girls, therefore, acquired a better understanding of the reason for their individual differences. This lessened their anxiety about their physiques. Actual weight was deemphasized, emphasis being placed instead on dress size and appearance. This approach was comprehensible to the girls and provided a realistic goal.

The course also covered food fads and fallacies, refreshments at teenage parties and record hops, snacks at the drugstore or at home, going out to dinner, school lunches, and the making of suitable substitutions, all in relation to either maintaining weight or continuing weight loss.

The nutritionist was pleased to note the degree of comprehension and interest exhibited. Some of the groups even requested extra evening discussions.

The diet used at the camp served a dual purpose. It helped the girls to lose weight, and it demonstrated the application of nutritional theory. Essentially, the diet was high protein, moderate fat, and low carbohydrate. The intake per day varied from 1,100 to 1,400 calories, depending on the menu.

The average intake was 1,250 calories per day. The protein intake was around 80 to 85 grams per day. Dietetic or low-calorie foods were not served except for an artificial sweetener, skimmed milk, and low-calorie soft drinks.

The professional staff believed that adherence to any diet, whether low calorie or high calorie, is directly related to the ease or availability of the foods prescribed and to the degree of normality of the diet in relation to the environment of the individual. Therefore, the campers were served a wide variety of foods commonly available throughout the country. They were not taught to count calories or to abstain from the so-called "forbidden" foods such as cake, pie, and candy. Rather, they were taught portion control of all foods. All summer the nutritionist used repeatedly, the phrase, "frequency and quantity."

Most professional persons are aware of the psychological impact of imposed restrictions on favorite foods, or on anything else that has become a source of pleasure to an individual. Because of this psychological effect, complete abstinence is extremely difficult to attain and, therefore, occurs rather infrequently. Consequently, it is always wise to set moderation rather than abstinence as a goal, wherever possible, and in recommending a regimen to consider the individuals' social and cultural environment. Otherwise, most programs involving restrictions, particularly of food, cannot be expected to achieve a very high degree of success. For this reason, the campers were given desserts occasionally, candy bars for a snack, and other "forbidden" foods periodically during the summer. They were taught how to incorporate these foods in their diet and still lose or maintain weight. There is no doubt, in the minds of the staff, that this lesson in moderation reinforced the girls' motivation and was responsible for the success of continued diet control after leaving the camp.

In short, throughout the series of discussions and the rest of the camp program, the campers were imbued with the idea that the ultimate solution of their weight problem rested on their own shoulders. They were happy to accept this responsibility, and their accomplishments were satisfactory. Since the program took place at a summer camp, it also included physical activities and sports.[16]

Each winter the degree to which the girls who attended camp the previous summer used their acquired dietary information afterward was evaluated by a followup program. All campers within commuting distance of Boston and New York were invited to meet with the nutritionist and the medical director each month from September through May. Their achievement was most encouraging. Many gave evidence of the satisfaction and security that comes from better overall adjustment, often including improved academic achievement.

As we have already pointed out, a program of nutrition reeducation involves not only teaching proper nutrition, but, more importantly, maintaining a high level of motivation in the group desiring this information. We believe that in this camp experience we have demonstrated that teenagers can be helped to achieve and maintain the appropriate degree of motivation by adults who accept the teenagers own goals, help them to understand how these goals can be achieved, and help them to share responsibility for achieving them.

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[1] U.S. Department of Commerce, Bureau of the Census: Statistical abstracts of the United States: population by age and sex 1930–60 (table 18). 1962.

[2] ———: Current population reports: population estimates. Series P–25, No. 232. June 22, 1961.

[3] Macy, Icie G.: Nutrition and the teenager: reference papers on children and youth. White House Conference on Children and Youth, Washington, D.C. January 1960.

[4] ———: Metabolic and biochemical changes in normal pregnancy. *Journal of the American Medical Association*, December 1958.

[5] Marchetti, A., et al.: Pregnancy and the adolescent. *American Journal of Obstetrics and Gynecology*, May 1950.

[6] Semmens, J., et al.: Teenage pregnancies. *Obstetrics and Gynecology*, July 1960.

[7] Johnston, J. A.: Nutritional studies in adolescent girls and their relation to tuberculosis. Charles C Thomas, Springfield, Ill. 1953.

[8] ———: Protein requirements of adolescents. *Annals of the New York Academy of Science*, January 1958.

[9] Macy, Icie G.: Nutrition and chemical growth in childhood: II. Original data. Charles C Thomas, Springfield, Ill. 1946.

[10] Stearns, Genevieve: Nutritional state of the mother prior to conception. *Journal of the American Medical Association*, November 1958.

[11] Eppright, Ercel S.; Roderuck, Charlotte: Diet and nutritional status of Iowa school children. *American Journal of Public Health*, April 1955.

[12] Food and Nutrition Board of the National Academy of Sciences, National Research Council: Recommended dietary allowances. Washington, D.C. Revised 1958.

[13] Hathaway, M. L.; Sargent, D. W.: Overweight in children. *Journal of the American Dietetic Association*, June 1962.

[14] Eppright, E. S.; Swanson, P. P.: Distribution of nutrients among meals and snacks of Iowa school children. *Journal of the American Dietetic Association*. March 1955.

[15] Spindler, Evelyn B.: Motivating teenagers to improve nutrition. *Journal of the American Home Economics Association*, January 1963.

[16] Peckos, P. S.; Spargo, J. A.; Heald, F. P.: Program and results of a camp for obese adolescent girls. *Post Graduate Medicine*, April 1960.

IN THE JOURNALS

Parents of the Retarded

The age at which parents place a severely retarded child in an institution appears as the crucial predictor of subsequent parental interest in the institutionalized child, in a study reported in the fall 1963 issue of *Social Problems.* ("Parental Interest in the Institutionalized, Severely Mentally Retarded Child," by Kenneth J. Downey.) The article offers an analysis of data culled from the clinical and administrative records of two State schools for the mentally retarded and from interviews with 143 families in the Chicago area who were on mailing lists of voluntary groups interested in the retarded.

Classifying each family by what he calls its "life cycle" (age of parents, length of marriage, age of oldest child, age of the retarded child, length of its institutionalization, and the life status of the grandparents), as well as by income and occupation, the author, who is associated with the State University of New York at Buffalo, measured the quality, range, and frequency of parental attention by number and length of visits and number of letters annually, as well as by other items. Prominent among his findings was that the family in the early stages of the life cycle shows less interest in the institutionalized child than the family in later stages; and that the more educated parents appear to place children at a younger age and to demonstrate less interest than parents with a lower degree of education.

The Future Family

Loss of traditional functions, increased mobility, drives for achievement, and materialism threaten today's family, according to an article by Charles W. Hobart in the November 1963 issue *Marriage and Family Living.* ("Commitment, Value Conflict and the Future of the American Family.") Demands of urban living may shape individuals into efficient, mechanical *doers*, incapable of deep emotional commitment to marriage and parenthood, warns the author. These trends, he says, call for a value revolution away from a materialistic production orientation toward a humanistic one, and he maintains that an affluent society in which overproduction is a problem can afford this kind of revolution. A renewed emphasis on *being* rather than *doing*, according to the author, would make the family and its concern with human relationships an organizing principle of society.

The Broad Approach

The few inroads into dependency which all our skills, legislation, campaigns, and projects have made to date, according to David R. Hunter, in the November 1963 issue of *Child Welfare*, reflect the tendency in this age of specialization "to respond in the singular"—for example, to a child welfare need with a single service. ("Child Welfare in Perspective.") The writer is with the Ford Foundation.

Noting that the social agency often has access to great community power through its boards, the author envisions its community role as catalyst, educator, mobilizer of forces and participant in priority setting. He sees the agency working with the board of education, the city planning department, the departments of welfare, recreation, health, public works, and other public and voluntary agencies, toward better education for slum children; breaking down artificial barriers to work, to reside where one wills, and to rise socially and economically; creating for youths job opportunities and a chance to participate in community affairs; and projecting manpower needs and preparing people accordingly.

Learning Mental Health

The school as an ideal setting for primary prevention of mental disorders—where professional school staff may channel the responses of children to crises into healthy, effective coping patterns—is envisioned by an associate professor of mental health at Harvard University School of Public Health, writing in the quarterly *Mental Hygiene* for October 1963. ("Opportunities for School Psychologists in the Primary Prevention of Mental Disorders in Children," by Gerald Caplan, M.D.)

Drawing guidelines for identifying crises-evoking situations which, he notes, differ according to child, Dr. Caplan classifies such situations into two main types: regularly occurring biopsychosocial transitional points (such as graduation from junior to senior high school) which affect large numbers of children and accidental happenings (such as the birth of a sibling) which are superimposed upon the first.

The author then sets out ways in which the school psychologist can directly intervene at the time of crisis with children who use poor coping mechanisms, by attempting to reverse their response patterns or by providing anticipatory guidance; or indirectly intervene through teacher training or consultation or through research.

Freedom to Learn

The often weakened inner resources of a child in foster care for meeting the challenge of academic learning, writes a social worker from Boston's Judge Baker Guidance Center in *Social Casework* for November 1963, stem sometimes from the very circumstances that bring the children into foster care. ("Children in Foster Care and Their Freedom to Learn," by Nancy Staver.) In a roundup of what she presents as prerequisites for academic learning in the case of the first grader, she portrays the child in foster care as likely to be deficient on each count: poor coordination or physical defect, often associated with conditions that led to placement; lack of ease about his own body functions—perhaps from fear that something he did or said caused his parents to abandon him; poor memory and inattention from the habit of escaping terrifying shouted words and violent scenes of parental fights; intolerance of tension and lack of energy not tied up in tension; distrust of adults and insecurity about his own ability and worth.

The writer, who is now an exchange social worker at the Tavistock Clinic in London, stresses the importance of helping the child build trust in his teacher and in the placement worker.

HOMEMAKING INSTRUCTION FOR HANDICAPPED CHILDREN

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INDEPENDENCE in homemaking and in activities of daily living are both part of the training of physically handicapped children in the Orthopedic Hospital School in Helsinki, Finland, in a program devised by the school's director, Anne Marie Krohn. Besides learning to dress themselves and comb their hair, children are expected to learn to wash dishes and do other household chores before they leave. They also study safety hazards with the goal of learning to temper courage with good judgment.

The education of the children's parents is another important part of the school program. Efforts are made to help them appreciate their child's potentials and limitations at each stage of development and to learn the importance of encouraging the child to be as independent as possible after he leaves the hospital. In addition, practical methods of removing architectural barriers are considered in relation to each child's home, his school, and the other facilities of his community.

Developing independence in homemaking for handicapped children has important social and economic values. Instead of being a constant care of his family as he is growing up, the handicapped child becomes increasingly able to take care of himself and may be able to continue to do so when his parents are no longer able to take care of him. He may even be able to look forward to being fully self-supporting and to having a home and a family of his own.

The psychological values of developing independence in homemaking are of even greater importance. Children who become self-sufficient in the demands of everyday living gain a feeling of pride and self-confidence. The satisfaction of achievement in self-care and household tasks may lead to the development of initiative that makes for progressively more independence.

The Finns are ingenious in fashioning gadgets and in developing adaptations that make it possible for handicapped children to carry on a maximum number of homemaking activities. Poor balance and crutches, for example, do not excuse a child from washing the dishes; a window washer belt attached to the sink gives the support needed and leaves the arms free. Long-handled mops, brooms, and dust pans make it possible to keep the house clean. Blocks under a bed may raise it to a height that permits the child to get in and out without help.

One-handedness is no bar to a child who wants to bake a custard pie; the egg beater can be stabilized and operated with one hand, and a little ingenuity plus a wire coat hanger can convert a rolling pin into a one-handed tool. Teenage girls who have only one usable hand even learn the special techniques for bathing and dressing a baby so that they may look forward with confidence to the possibility of caring for children of their own.

Being confined to a wheel chair does not preclude the possibility of learning to take complete care of a home. When working surfaces are lowered and knee room provided, children are soon able to prepare meals. Short-handled mops, brooms, and dust pans make it possible for them to keep the house clean.

Boys are also included in the instruction in independence in homemaking. Home-centered occupations are thoroughly explored with them through which they might avoid the fatigue, time, and expense of transportation often involved in connection with employment outside of the home. Both boys and girls are helped to think about the possibility of "changing roles" when physical limitations make it more feasible for the husband to take over some of the responsibility of the household while the wife becomes a wage earner outside of the home.

Besides learning to master household chores, the children in the hospital school receive special instruction in nutrition and in the importance of avoiding obesity. Foods are studied from the point of view of cost, nutritional value, and ease of preparation as well as consistency and palatability.

Clothing and grooming are also important considerations. Teenage girls learn to adapt patterns and to make clothing to disguise their disabilities and permit them to become as independent as possible in dressing. Clothing selection is considered from the point of view of comfort, cost, and easy care with special emphasis on color, design, and other factors that contribute to becomingness.

Older girls study the problems of home management from a questioning approach: *What* is the job? *Why* is it necessary? *When* should it be done? *Where* should it be done? *How* should it be done? *Who* should do it? They learn that management is far more important than "gadgets" in developing independence in homemaking activities.

Discussion of problems relating to the adaptation in home furnishings and the possibilities for removing architectural barriers is approached from the point of view of safety, comfort, cost, and convenience. Experiments in adaptation are encouraged in every way possible.

Implications

Much can be learned from this Finnish program that could be applied to children in the United States. While our special schools for handicapped children frequently have homemaking teachers on their staffs, the trend in educating handicapped children is to include them in regular public schools, whenever possible. This has many advantages in helping the children to become part of the mainstream of American life, but the goal cannot be reached without special effort. To find out what was being done here about helping handicapped children achieve independence in homemaking, the author sent a questionnaire to State supervisors of home economics education. Nearly all of the replies indicated that guidance counselors seldom direct physically handicapped children to home economics classes; and that handicapped children who are included in regular home economics courses are dependent upon the ingenuity of the teacher for instruction fitted to their particular needs. The majority of the replies indicated that "handicapped children are usually given something quiet to do."

When the space under a sink is wide and low enough for a wheel chair, as it is at the Helsinki Orthopedic Hospital School, the patient can reach the dishes.

If handicapped children here are to reach their greatest potential for independence in homemaking, steps need to be taken to bring about:

- Greater awareness on the part of school administrators, guidance officers, school social workers, and members of health-related professions of the importance of teaching independence in homemaking to handicapped children in the public schools as well as to home bound children.

- The modification of architectural barriers which prevent handicapped children from having safe access to school and community facilities.

- Close cooperation between school health authorities, guidance counselor, school social worker, homemaking teacher, and parents to reach an agreement on each handicapped child's physical potential and the safeguards he needs.

- Greater awareness on the part of homemaking teachers of the possibilities they have for contributing to the independence of handicapped children.

- More understanding on the part of nonhandicapped children of the importance of treating handicapped children as one of the group rather than as curiosities or objects of ridicule.

- Greater efforts to help handicapped children themselves to accept their limitations and to make the most of their capabilities.

- Adaptation of homemaking laboratories in the public schools to meet the needs of physically handicapped children or those with low energy.

- The preparation of concise resource material focused on independence in homemaking for handicapped children for use in the training of homemaking teachers.

- Adjustment of teaching schedules, when necessary, to enable teachers of homemaking to give time to handicapped children as fully participating members in homemaking classes.

HERE AND THERE

Federal Legislation

On October 31 President Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. The law authorizes, over a period of 4 years ending June 30, 1967, appropriations of $26 million for project grants to help public and nonprofit institutions build centers for research in mental retardation and related aspects of human development; and $32.5 million for project grants up to 75 percent of cost, for the construction of university-affiliated facilities for the mentally retarded. In addition, appropriations totaling $67.5 million were authorized for grants to the States (with variable matching) through 4 fiscal years ending June 30, 1968, for construction of public or other nonprofit facilities for the mentally retarded.

The legislation also authorized $150 million to be appropriated over 3 fiscal years, beginning with 1965, for grants to States (with variable matching) for the construction of public or other nonprofit community mental health centers; and $47 million to be appropriated over 3 years ending with fiscal 1966, for grants—with no matching requirements—to public or nonprofit institutions of higher learning to help broaden and strengthen programs for training teachers of mentally retarded children and children with specified handicaps such as serious emotional disturbance, deafness, speech impairment, visual defect, or crippling conditions; and $6 million for 3 years ending in June 1966, for grants for research or demonstration projects related to educating handicapped children requiring special education.

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Another statute enacted by the 88th Congress last fall is the "Health Professions Educational Assistance Act of 1963." This authorizes appropriations totaling $175 million for fiscal years 1964 through 1966, for grants to be made by the Surgeon General of the Public Health Service to public or nonprofit schools of medicine, dentistry, nursing, and other health professions, for construction of new, replaced, or rehabilitated teaching facilities.

The legislation also authorizes appropriations totaling $30,700,000 during the same fiscal period for a program of loans to students of medicine, dentistry, or osteopathy. Under the Act, the Secretary of Health, Education, and Welfare may enter into agreements with public or other nonprofit schools of these disciplines to establish loan funds. Additional funds are authorized to be appropriated for this program during the following 3 fiscal years to enable students who had received loans under the program before the end of fiscal 1965 to continue their education.

Day Care

The "gross inadequacy" of present child-care facilities in communities across the country was underscored by the President's Commission on the Status of Women in its report to President Kennedy, submitted in mid-October after a 22-month study of major aspects of women's activities in American life. The report of the 24-member body, which began its work under the chairmanship of the late Eleanor Roosevelt, found, among other facts, that licensed day-care facilities are available to only about 185,000 children in this country; and that in nearly 500,000 families with children under 6 years the mother is frequently the family's sole support, in 117,000 families with children under 6 only a father is in the home, and in almost 3 million families with children under 6 the mothers work outside the home though a husband is present.

Entitled "American Women," the report also includes findings on education and counseling; other aspects of home and community; women in employment; and labor standards.

Among other recommendations, the Commission urged that:

- Child-care services be available for children of families at all economic levels, and that such services maintain proper standards of child care whether the services are in the home or in a center.
- Volunteers' services in child-care arrangements be made more effective through coordinated planning among agencies and organizations for recruitment, training, placement, and supervision, and the number of volunteers augmented through tapping the potential reservoir of youth, retired people, and women not now in volunteer activities.
- Tax deductions for child-care expenses of working mothers be kept commensurate with the median income of couples when both parents are engaged in substantial employment; additional deductions be allowed for children beyond the first; the 11-year age limit for children whose cost of care can be deducted be raised.
- Family services under public and private auspices to help families avoid or overcome breakdown or dependency and set up a soundly based home life and professionally supervised homemaker services be strengthened, extended, or established where lacking.
- Community programs make comprehensive provision for health and rehabilitative services, including easily accessible maternal and child health services, accompanied by education to encourage their use.

The Commission's report is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402, for $1.25.

For Youth

A survey of a nationwide sample of 3,000 persons who failed the trainability tests of the Armed Forces was begun last fall under the direction of the United States Department of Labor and the Selective Service System. Designed to learn something about these rejectees' characteristics, goals, and problems, the survey is part of the work of the Task Force on Manpower Conservation, appointed by President Kennedy last September.

This body, composed of the Secretaries of Labor, of Defense, and of Health, Education, and Welfare; and the Director of the Selective Service System, with the Secretary of Labor as chairman, has been charged with preparing a program to guide, test, counsel, train, and rehabilitate young men disqualified for military service under the Selective Service System because of failure to meet the physical or mental standards of the Armed Forces, and to report to the President by the first of January 1964. In announcing its creation, President Kennedy noted that the most common deficiency among the approximate 25 percent of draftees who failed the mental test in their Armed Forces examination in 1962 was the inability to read or do simple arithmetic. "Today's military rejects include tomorrow's hard-core unemployed," he said.

The formation of a Presidential Task Force to focus on this problem was stimulated by the work of the Subcommittee on Community Services for Selective Service Registrants of the Interdepartmental Committee on Children and Youth. This subcommittee is composed of representatives of the Selective Service System, the Public Health Service, the Office of Education, the Vocational Rehabilitation Administration, the Bureau of Employment Security, and the Department of the Army. As a result of the committee's work the Public Health Service set up three demonstration projects in 1962 and 1963 in New York City, Philadelphia, and Denver, referring on a voluntary basis Selective Service registrants who fail the Armed Forces preinduction medical examinations to sources of medical care and counsel.

The Negro baby born in America today—regardless of the section or State in which he is born—has about one-half as much chance of completing high school as a white baby born in the same place on the same day, one-third as much chance of completing college, one-third as much chance of becoming a professional man, twice as much chance of becoming unemployed, about one-seventh as much chance of earning $10,000 per year, a life expectancy which is 7 years less, and the prospects of earning only half as much.

No American who believes in the basic truth that "all men are created equal, that they are endowed by their Creator with certain unalienable rights," can fully excuse, explain, or defend the picture these statistics portray. Race discrimination hampers our economic growth by preventing the maximum development and utilization of our manpower. It hampers our world leadership by contradicting at home the message we preach abroad. It mars the atmosphere of a united and classless society in which this Nation rose to greatness. It increases the costs of public welfare, crime, delinquency, and disorder. Above all, it is wrong.

Therefore, let it be clear, in our own hearts and minds, that it is not merely because of the cold war, and not merely because of the economic waste of discrimination, that we are committed to achieving true equality of opportunity. The basic reason is because it is right.

JOHN F. KENNEDY, in his message to Congress on civil rights, February 28, 1963.

Services in Housing

A new center to bring services related to employment, health, education, and welfare to low-income families living in public housing developments was opened last October in Pittsburg, Calif., the third city selected by the Joint Task Force on Health, Education, and Welfare Services and Housing for demonstrations of concerted efforts among a variety of local, State, and Federal agencies to raise the levels of living of occupants of low-rent public housing. Other concerted services projects are in New Haven, Conn., and St. Louis, Mo. (See CHILDREN, May–June 1963, p. 121; and November-December 1962, p. 242.)

The new service center in Pittsburg is located in a neighborhood containing two large housing developments, El Pueblo and Columbia Park, with a total of 302 dwelling units, and is being operated under the sponsorship of the Contra Costa (County) Council of Community Services. The council worked closely with the local housing authority in developing the organization and plan for the project. Also in the neighborhood and assisting in the project is the First Neighborhood Council of Pittsburg.

For Health

By September of 1963, the Family-Centered Health Service Project, conducted since May 1962 by the Sacramento County (Calif.) Health Department to coordinate health services for low-income families, had served more than 170 families, only 48 percent of whom had previously been known to the health department. A project team, including a physician, public health social worker, and two public health nurses, directs its services to families as a unit not only providing traditional maternal and child health supervision but also encouraging discussion of the total family's physical, emotional, and social problems, and making referrals to appropriate community services.

The project has also been designed to reevaluate current local maternal and child health programs; to gauge the effectiveness of the liaison role of the public health nurse as part of the team; and to explore the availability and utilization of community services.

Thus far the families' major social problems, excluding illegitimacy, have been found to be economic dependency (72 percent), marital discord (31 percent), antisocial behavior (27 percent), and family and child malfunctioning (20 percent). A survey of medical needs is currently under way.

The project is supported by the California Department of Public Health, with the help of Federal maternal and child health services funds.

Social Research

Evaluation of a 9-month demonstration of an intensive social group work approach to raising the aspirations of deprived youth, completed last September, indicates that the approach was effective in changing negative attitudes and values, according to the experimenters, John W. Cox and Clarence E. Barnes. Conducted by the Goodrich-Bell Neighborhood Center in Cleveland's inner city Hough District—a high delinquency low-income area—with the assistance of a research grant from the Social Security Administration, the project focused on developing desirable male role behavior and work preparation among 33 fatherless Negro boys, ages 10 through 13, not previously served by the agency. Carried out with the cooperation of the boys, to whom the target problems had been identified at the outset, the program included the direct teaching of socially accepted values by the group worker; and strict prestructuring of goals and program content.

Two control groups of the same size were selected for comparative measurements. Control Group I received the services offered in the agency's traditional group work program—centered on leisure time activities, such as hikes, bowling, and parties. Control Group II was not included in any program.

Activities in the intensive program offered the experimental group included visits to places of employment; trips to homes of Negro success models; lectures; individual conferences and outings; rewards for achievement; and regular meetings with the boys' parents. There were few of the usual leisure time activities.

At the end of the period attitudes were measured by several objective tests, analyses of records, and interviews with the boys and with their parents. The experimental group showed, in comparison with the control groups, more improvement in school grades, school effort, levels of aspiration, and general attitudes toward school. On the basis of interview behavior, the clinical psychologist identified 17 out of 20 of the boys who belonged to the experimental group as members of that group without having had prior knowledge of this fact.

Cost Analysis

A number of projects to devise or test methods for determining costs in child welfare services are under way in various parts of the country. These are focused on:

- *Day-care centers*, in a project under way at Brandeis University, with Federal funds made available under the child welfare services research and demonstration program.
- *Foster family care and adoptions*, in a project sponsored by the California Department of Social Welfare, with the use of Federal child welfare services funds, and the Child Welfare League of America.
- *Residential treatment centers*, in a study of costs in 21 residential treatment centers and 2 therapeutic day schools, sponsored by the Child Welfare League of America.
- *Voluntary family and children's agencies*, in a project of the Family Service Association of America to develop a cost analysis method based on a time analysis manual published by the Association in 1962.
- *Institutional care*, in a joint project of the Children's Bureau and the Child Welfare League of America to promote the use of uniform cost accounting procedures among institutions caring for children. (See CHILDREN, May–June 1963, p. 120.) Requests from public departments, institutions, health and welfare councils, and other organizations on the use of the League's "Manual for Cost Analysis in Institutions for Children," the focus of the project, may be addressed to the director, Robert Elkin, in care of the Children's Bureau, U.S. Department of Health, Education, and Welfare, Washington, D.C., 20201.

School Dropouts

A recently published study of the records of school dropouts in Syracuse, N.Y., during 1959–60 reports that about two-thirds of those for whom IQ scores were available had scores of 90 or better. Nevertheless, four-fifths of the dropouts were found to be at least 1 year retarded in school.

The study was carried out by the Syracuse University Youth Development Center. Sources of the data were: the Syracuse Board of Education, the New York State Employment Service, the Syracuse Armed Forces Examination Station, the Onondaga County Department of Public Welfare, the Central Registry of Juvenile Offenders, and the Syracuse Police Department.

While most of the dropouts left school during their first 3 years in high school, 13 percent dropped out during the 8th grade and 3 percent during the 7th grade. Boys represented 55 percent of the dropouts, but they tended to be older than the girl dropouts at the time of leaving school: 55 percent of the girls left school before the age of 17, compared with 43 percent of the boys. The total dropout rate in Syracuse during the year was 54 per 1,000.

Most of the dropouts were found to have come from "relatively poor families," with more than 40 percent having received public welfare assistance at some time. Slightly more than a fourth of the total (27 percent) were found to have had contact with law-enforcing agencies at some time. Of these, 43 percent had had only one contact.

Information on the type of work secured by those who received work permits showed bowling alleys as the top industry providing first jobs to boys; variety stores and hospitals for girls.

The report of the study is available for 50 cents from the Center, 926 South Crouse Avenue, Syracuse, N.Y., 13210. ("The School Dropout Problem: Syracuse," by S. M. Miller, Carolyn Comings, and Betty Saleem.)

Mental Retardation

Six previously undiagnosed cases of phenylketonuria (PKU) were uncovered during the summer of 1963 among immediate family members and close relatives of 17 PKU patients, in the first phase of a program conducted by the Division of Community Services for the Mentally Retarded, Maryland Department of Health. Under the program, such high risk groups are being screened for the disorder and educated about it—particularly about the importance of early testing to prevent mental retardation. According to a report prepared by Lloyd I. Kramer, the program's first phase concentrated on families of the PKU patients then known to the State health department whose parents reside in the city of Baltimore, Baltimore County, and Anne Arundel County. The program is scheduled to continue in the summer of 1964, centering on the families of the 17 other patients whose parents live in the remaining Maryland counties.

With the cooperation of local health departments and their public health nurses, the investigator visited homes of the patients, administered questionnaires to gauge the parents' knowledge of the disorder, distributed pamphlets on PKU, asked for names and addresses of aunts, uncles, and first cousins of the patients, and collected urine samples. These samples were tested with ferric chloride and Phenistix, and if questionable or positive, further tested at the

State health department laboratory with 10-percent ferric chloride and dinitrophenylhydrazine. In a number of cases, serum analysis for abnormal levels of phenylalanine were performed. Visits to close family members were arranged for health education and screening purposes; relatives living outside Maryland were tested through eight other State health departments.

The 19 families visited in the first phase were found to have 10 new cases. The 6 cases previously undiagnosed involved children from 10 months to 13 years of age, unknown before the survey to the Maryland Department of Health. Ten of the screened families were not aware of the importance of early testing, 11 did not know that the condition was inherited, 8 knew that the condition was treatable through diet, and 7 had a good understanding of the child's condition.

Miscellaneous

Since March 1961, the Workshop of the Children, Inc., in New York City's Greenwich Village, has offered tools, simple materials, and a place to build such things as bicycles and kitchen cabinets to about 520 chidren from preschool age through 18 years who have wandered in from the street.

The project uses a full-time staff of two—a painter and an administrative director, Kay van Deurs, a professional writer who oversees the carpentry, bicycle-building, sandal-making, and other activities. In addition, some 20 persons ranging from painters or potters to doctors volunteer time to the workshop, which serves from 40 to 60 children at each session.

The project is the fruit of a mutual interest between its director and neighborhood children that flowered when, as a newcomer on the block, she was building and painting furniture on the sidewalk and the children gathered round to watch. After 2 weeks a child suddenly offered to help and another followed suit. When they timidly asked if they could make something for themselves, they were invited in and supplied with wood, tools, ideas, and supervision.

The workshop, which was incorporated as a nonprofit organization a year ago, is financed by contributions from individuals, organizations and foundations. In addition, hundreds of neighbors, according to the director, contribute "boards, old shirts, vacuum cleaners, potatoes—whatever they can."

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By mid-December the 16 mm. film "Reluctance to Go to School," with a 9-page discussion guide for use in training public welfare staff, had already been lent to 33 agencies since its release toward the end of May 1963. The film script and guide were written by the Children's Bureau and the Bureau of Family Services, U.S. Department of Health, Education, and Welfare, and produced through the Cooperative Project on Public Welfare Staff Training which was financed by the Field Foundation. (See CHILDREN, May–June 1963, page 121.) It may be borrowed from the Division of Technical Training, Bureau of Family Services.

The theme of the film, which takes 17 minutes to show, is the common base for working with families and children. The guide, suggesting 1½ hours for showing and discussion, points out various aspects of social work knowledge and skills demonstrated in the film which can be made the focus of the discussion in training sessions with workers, supervisors, or teachers.

Guides and Reports

THE ENCYCLOPEDIA OF CHILD CARE AND GUIDANCE. Sidonie Matsner Gruenberg, editor. Doubleday & Co., Inc., Garden City, N.Y. Revised edition. 1963. 1,016 pp. $7.50.

The revision of this 10-year-old encyclopedia brings the health and child development material up to date and adds an article on juvenile delinquency.

A FAMILY BUDGET STANDARD. The Budget Standard Service, Research Department, Community Council of Greater New York, 345 East 45th Street, New York 17. 1963. 76 pp. $3.

Revealing the changes in American living standards since World War II, this entirely new revision of a previous publication is designed as a guide for use by social and health agencies in New York City.

THE PUBLIC WELFARE CRISIS IN THE NATION'S CAPITAL: a call to the conscience of the community. Metropolitan Washington Chapter, National Association of Social Workers, 1136 19th Street NW., Washington 6, D.C.; Commission on Human Resources of the Washington Center for Metropolitan Studies, 1726 Pennsylvania Avenue, NW., Washington 6, D.C. 1963. 64 pp. $1. Quantity rates available.

The report of a 3-month study, made by a special committee of the local NASW Chapter, of the District of Columbia's program of aid to families with dependent children, with emphasis on policies and regulations which result in denial of assistance to families in need and in many instances in family breakup. Fifteen recommendations are included to increase the adequacy and availability of assistance and provide staff with the time and ability to focus on social rehabilitation as well as on eligibility determination.

CHILD ABUSE—PREVIEW OF A NATIONWIDE SURVEY. Vincent De Francis. Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo. 1963. 20 pp. 25 cents.

A paper presented at the 1963 annual forum of the National Conference on Social Welfare, reporting on a preliminary survey made in 1962 by the American Humane Association of the incidence, characteristics, and patterns of child abuse; and of community approaches to prevention and treatment.

BOOK NOTES

THE MENTALLY RETARDED CHILD. Essays based on a study of the peculiarities of the higher nervous functioning of child-oligophrenics. Edited by A. R. Luria. Translated from the Russian by W. P. Robinson. English translation edited by Brian Kirman. The Macmillan Co., New York. 1963. 207 pp. $7.50.

How the electroencephalogram distinguishes mentally defective children from normal children with delayed intellectual growth, delineates the uniqueness of the defect, and helps detect unsuspected deafness is demonstrated in this collection of eight essays by Professor Luria and five of his colleagues at the Institute of Defectology in the Academy of Pedagogical Sciences of the Russian Socialist Federative Soviet Republic. This volume also sets out some basic facts relevant to the development, the clinical characteristics, and other unique features of the higher nervous activity of the mentally retarded child.

SPEECH AND THOUGHT IN SEVERE SUBNORMALITY. Neil O'Connor and Beate Hermelin. The Macmillan Co., New York. 1963. 122 pp. $4.

Probing into the processes that contribute to cognitive defects, the authors, research psychologists with the Institute of Psychiatry of the University of London, studied groups of people with IQ's between 25 and 50—mostly children from 10 to 16—against a background of findings from others' experiments. Their account is organized into nine chapters that compare intelligence and thinking, learning and problem solving, thought and language, recall and recognition, and visual perception of "mongols" and other persons of the same degree of subnormality, and of intellectually normal children.

One of the final chapters, offering theoretical and practical implications of the evidence, stresses that the deficits of those with IQ's from 25 to 50 appear to be in the acquisition of information rather than in perception, retention, or transfer ability, impairment of acquisition coming partly from the inability to focus on relevant stimulus features. Thus, the authors suggest, material to be learned must be presented at high intensity levels with emphasis on relevant aspects of stimuli and with sufficient frequency.

Some other conclusions: logic in linguistic structure does not necessarily imply logic in other operations; under certain conditions, "mongols" have a lower basic level of skin conductance than "nonmongols" of the same IQ; and "imbecile" children are relatively superior to normal children in tactile inspection recognition.

THE ECONOMICS OF WELFARE POLICIES. Margaret S. Gordon. Columbia University Press, New York. 1963. 159 pp. $3.

The question of whether or not the "complex constellation of American public welfare programs is adequately designed to contribute to economic stability" the author describes as one of the "vacuoles" in economics literature of today. Associate director of the Institute of Industrial Relations of the University of California, she discusses in this book the economic effects of welfare programs.

The book opens with a brief historical sketch of public welfare expenditures. This is followed by a comparison of such expenditures in this country with those in foreign countries, showing that in European countries and in the British Commonwealth these "tend to represent an appreciably larger portion of the national income than in the United States;" some data on the impact of welfare programs on income redistribution, indicating that most of the vertical redistribution in a year occurs within the income group under $5,000; and analyses of the economic theory, policy, and structure of our social insurance programs.

The author concludes with the suggestion that economists pay greater attention to such questions as: "Does a mature economy run a serious risk of retardation of growth if it fails to relieve pockets of poverty . . .? Does the need for increased saving in an immature economy preclude the possibility of emphasis on welfare policies in the early stages of development?"

One of a series of three dealing with the economics of health, education and welfare, the work was commissioned by the Ford Foundation.

THE EMPLOYED MOTHER IN AMERICA. F. Ivan Nye and Lois W. Hoffman. Rand McNally & Co., Chicago, Ill. 1963. 406 pp. $6.

To throw light on the massive movement of American mothers into paid employment, the authors, who are associated, respectively, with Washington University and the University of Michigan, have culled and analyzed available research findings on the subject. They were aided by 17 sociologists, social psychologists, economists, and other experts, including scholars in the field of child development and family relationships. Together they scrutinized particularly the effects of maternal employment upon the adjustment of children and upon the marriage relationship.

The four parts into which the book's contents are organized—"Why They Work," "Effects on the Children," "The Husband-Wife Relationship," and "Adjustment of the Mother"—include in each case a summary by one of the authors directed toward making order of the findings and pointing up areas for further research. Author Hoffman, for example, gauging the effects of mothers' working on the children, finds that the data indicate "families in which the mother works 'only occasionally' are indeed more unstable than those in which the mother works regularly." Children from such homes, the author points out, tend to show the effect of basic family instability which is deeper and more pervasive than the effects of unstable maternal employment in and of itself.

Generally, the research findings fail to indicate that children of working mothers are either better or more poorly adjusted than children of nonworking mothers, the authors report. Author Nye concludes the book with a chapter on the mother's adjustment, indicating some of the social-cultural complexity involved in assumption by mothers of the provider or co-provider role.

YOUTH: change and challenge. Edited by Erik H. Erikson. Basic Books, New York. 1963. 284 pp. $6.50.

The way the world of youth interacts with the adult world in an unending spiral of ambivalence, depicted in an early chapter, flows like an omnipresent undercurrent through much of this book—an essay symposium on the social and psychological issues of youth by such scholars as Erik H. Erikson, Bruno Bettelheim, S. N. Eisenstadt, and Kasper D. Naegele. Ten of the book's papers appeared in a 1962 issue of *Daedalus*, the journal of the American Academy of Arts and Sciences; three others and the introduction by Professor Erikson were added to complete the book.

The first group of papers looks at adolescence from the perspectives of evolution, the generations, society, and nations. Here, Erikson describes youth as the point at which "the life history intersects with history . . . individuals are confirmed in their identities, societies regenerated in their life style." Here, also, Naegele suggests that a source of inter-generational friction is adults' unrealistic, idealistic image of youth, which underplays such negative qualities as youth's intensities and shifting moods that do exist.

The next group of papers focuses on youth in the context of American society, and a third group on young people in Japan, France, and Russia. In discussing Russian youth, George Sherman wonders what will become of the "revolutionary momentum" in Russia where "calculation rather than spontaneity is a young person's guide to success."

The new papers include one by Associate Justice Arthur J. Goldberg of the Supreme Court of the United States on the occupational outlook for American youth—in which he emphasizes the importance of education to prepare youth for meeting change in the economic environment; and two others, on the sit-in movement in the South and the Peace Corps, by participants of these movements.

READERS' EXCHANGE

DELSORDO: ***Breaking the circle***

In his illuminating contribution to the growing literature on child abuse [see "Protective Casework for Abused Children," CHILDREN, November–December 1963], James Delsordo categorizes five types of abuse as distinguished by parental causal factors: (1) the abuse of the "mentally ill parent;" (2) "overflow abuse," resulting from disorganized parent personality; (3) the battered child syndrome, in which the abusive parent is overly dependent; (4) "disciplinary abuse," coming from the strict, unrelenting disciplinarian; and (5) "misplaced abuse," resulting from the projection of a parent's conflict onto the child in the form of misplaced hostility. Out of the 80 cases studied, more than half (43) were cases of "misplaced abuse."

Some questions may be raised in regard to these categories. Do some situations represent two categories? I am reminded of the attempt of a small child welfare services committee of the Missouri Division of Welfare to classify case records of neglectful parents after reading Glickman's "Casework With Parents." Invariably, there were vast differences of opinion among the case readers as to which classification "Mrs. S," "Mr. G," and "Mr. P" fell into, with conclusions of overlapping.

As social casework moves into a scientific sphere, there seems to be an urge to classify and categorize. This is done on the basis of: we must know what we are dealing with, to know what to do with that which we are dealing. Frequently, we forget to research specifically what we did with what we were dealing with and what happened as a result. The study Mr. Delsordo describes does not seem to have been centered on treatment within the defined categories. Thus the reader is left with a number of questions:

Can the more than 50 percent of parents acting out their own suffering through "misplaced abuse" be helped to fulfill their parental role? What specific kinds of help have proved effective? How does the treater's self-knowledge and handling of professional self in dealing with the zenith of failure in parenting, "child abuse," affect treatment?

Could there be additional research focused on the specifics of treatment with parents who emotionally neglect their children, physically abuse them, "batter" them, and physically neglect them, in an attempt to assist in ending the vicious circle of the same begetting the same? The author seems to indicate that these parents are for the most part untreatable, and that placement is the way out. Let us weigh this way out with the findings of Maas and Engler. ["Children in Need of Parents," Richard E. Maas and Henry S. Engler. Columbia University Press, New York. 1959.]

Lorena Scherer
State Child Welfare Supervisor, Missouri Department of Public Health and Welfare

Author's reply

Lorena Scherer is, of course, accurate in her observation that my article does not highlight certain areas of concern which she sees as needing extensive exploration. This is largely due to my preference in selecting and sticking to a central focus. I think, however, that some of the shortcomings which she attributes to my article may be misplaced.

I do not suggest placement as a way out; I suggest it as a way in. Miss Scherer's inability to grasp this concept may stem from her attempt to equate successful treatment with the caseworker's ability to *keep* all the family members under the same roof. My experience has been that when placement is indicated, it takes place in a conscious and thoughtfully guided process, and that it may represent the epitome of professional service. Do we not frequently have to break physically the circle of damaging interaction in order to break it psychologically? Miss Scherer's conviction seems to be that separation of parents and child is the end of their relationship. I believe it can well be the real beginning.

Mass and Engler do clearly point up the fact that many children in placement become lost to their parents. But they do not in any way advocate that children who are being physically and emotionally damaged by their parents should remain at home merely because there are some deficiencies in foster care and institutions. If parents do not maintain meaningful contact with their children in placement, is it not distorting the hard, realistic facts to suggest that the placement was therefore inappropriate and ill-advised?

James D. Delsordo
Departmental Supervisor, Children's Protective Service, Pennsylvania Society to Protect Children from Cruelty, Philadelphia

CHILMAN and KRAFT: *Mothers' groups*

The staff of our project on the use of group treatment in reducing dependency in AFDC families appreciated the opportunity to read the article by Catherine S. Chilman and Ivor Kraft in the July-August 1963 issue of CHILDREN ("Helping Low-Income Parents: I. Through Parent Education Groups"). In our research project we have a mothers' group similar to those described. The nine mothers are of Latin origin. They are older than the mothers in our other groups, have had little education, know little English, have had no previous affiliations, and are members of families with many problems, including long-time dependency on public assistance.

We are now at midpoint in group treatment. Attendance has been good. The mothers like the sociability which allays their loneliness. These mothers either feel a sense of helplessness about the problems of their adolescent children or they exercise overly tight control. Our effort is to improve their skill in recognizing the needs of children and in finding solutions for appropriate parenting. We are also working on helping them with their own behavior, their homemaking, and their use of welfare department services.

We agree with Drs. Chilman and Kraft that the use of refreshments adds warmth and free communication to the group sessions. Mothers take pride in bringing their own pastry, fruit, or flower arrangements. One member has had the group meet at her home and others would like to do so. The personal appearance of the members and their housekeeping have markedly improved. This has happened although grooming has not as yet been a focus of the sessions.

Some members take pride in getting to the group independently. Others, because of physical handicaps or distance from the meeting place, are transported by the leaders. This service seems to enhance the mothers' feeling of importance.

Fortifying the necessary courage to speak English and to attend English classes has been a focus of treatment. In most of the homes the mothers speak to their children in Spanish. The children reply in English. We have observed that this limits the interaction between parent and child in many significant areas. The group is conducted in part in English and in part in Spanish. We perceive that the mothers know more English than they had felt safe in using before the sessions started but that they had not comprehended messages from school or other community resources.

Gertrude M. Hengerer
Executive Director, Family Service Association of Palo Alto and Los Altos, Calif.

ADDISS: *Implications for education*

In her article, "Job-Related Expenses of the Working Mother" [CHILDREN, November-December 1963], Luise K. Addiss makes clear that the working mother is not a new phenomenon in our society, that what is new is the locale of her work—away from home where she cannot combine the care of children with economically productive work. As we cannot return to the old way of life, we must find ways to cope with the many issues involved in a mother's employment today. One of these is recognition of the additional expenses that Mrs. Addiss identifies—the cost of child care, of special types of clothes, of additional meals, and the like.

Mrs. Addiss shows that through counseling some mothers may be helped to evaluate costs of employment, but what of the majority of mothers who are never seen by a helping agency? Would the Children's Bureau now publish a booklet addressed to young parents and homemakers incorporating the findings of this article? The young mother considering employment would not necessarily be deterred by understanding that approximately one-third of her earnings would be swallowed up by certain job-related costs. The reality of our economy is that many families do need the remaining two-thirds of the wife's earnings for either a subsistence level of living or for enriching the lives of family members.

A basic service which is needed, according to the author, and this is heard on all sides if one listens to young families, is high quality day-care service for children. Women themselves might be more creative about work plans if industry finds it too difficult to provide enough part-time jobs. Women in pairs might be responsible for one job as co-employees, each of whom would then be a part-time worker. Such a pair might be somewhat flexible about who works what hours and about the sharing in the care of both sets of children.

Mrs. Addiss' illustrations are of families that have little capacity for money management. We know from other research that family finances are the most common cause of husband-wife friction. This suggests the need to teach home management, including the management of family finances, in our high schools. Of equal importance would be the teaching of child nurture and guidance to both boys and girls so that they could make wise decisions in relation to their children.

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CHILD WELFARE SERVICES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 406. 1963. 42 pp. 25 cents.

This illustrated pamphlet, prepared for interpretive purposes, describes the variety of social services for children and their parents which comprise a rounded community program for child welfare, how they operate, the needs behind them, and their goals in strengthening family and community living. Particularly emphasized is the role of the lay citizen in determining the adequacy of his own community's program and taking steps to foster improvement.

CHILDREN AND NEGLECT—HAZARDOUS HOME CONDITIONS. Claire Hancock. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services. 1963. 59 pp. 40 cents. Single copies available on request from Public Information Office, Bureau of Family Services.

Intended as a guide for all levels of public welfare staff in assessing and dealing with parental failure, with special emphasis on children in the program of aid to families with dependent children, this booklet presents criteria for determining the existence of child neglect and social and psychological concepts for policy development and practice in child protection.

SLUMS AND SOCIAL INSECURITY. An appraisal of the effectiveness of housing policies in helping to eliminate poverty in the United States. Alvin L. Schorr. Department of Health, Education, and Welfare, Social Security Administration, Division of Research and Statistics. Research Report No. 1. 1963. 168 pp. 50 cents.

Mirroring the concept that decent housing must be a keystone of any antipoverty program, this research report draws on interdisciplinary research sources to look at the interaction between housing and continuing poverty and insecurity in the United States. It measures the cumulative impact on large segments of people of housing arrangements and urban renewal programs; and relates these to the ways families may choose in order to change their economic condition or climb out of poverty.

STATISTICS ON PUBLIC INSTITUTIONS FOR DELINQUENT CHILDREN: 1962. Duplain R. Gant. Department of Health, Education, and Welfare, Children's Bureau. CB Statistical Series No. 70. 1963. 32 pp. Single copies available from the Bureau without charge.

Reports on data gathered on a nationwide basis for the fiscal year July 1961–June 1962 which relate to the number of delinquent children committed and discharged from public training schools, number of institutional staff, and costs. One of the findings shows that institutions with populations of less than 150 children—the maximum number generally recommended—have the lowest returnee rate.

MENTAL RETARDATION. A National Plan for a National Problem. Chart Book published for the President's Panel on Mental Retardation by the U.S. Department of Health, Education, and Welfare. 1963. 69 pp. 45 cents.

Contains 32 graphic charts with annotations, pointing up the needs behind the major recommendations made in the report of the President's Panel on Mental Retardation (see CILDREN, January–February 1963, pp. 29–31).

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A CRESCENDO of joyous noisemaking at the end of the game—an event likely to bring out the teenager's taste for the radical in speech, dress, food, and behavior. Whether youth's idiosyncracies manifest an adolescent subculture hostile and distinct from adult norms and values or whether they are merely exaggerated versions of adult behavior is a question explored in the article beginning on page 43.

◂ *the authors*

Robert Bealer (right) directs longitudinal research about adolescent career patterns and values, and teaches sociology theory at Pennsylvania State University, where Fern Willits teaches statistics and social psychology. She is engaged currently in research on school dropouts. Peter Maida is studying socialization practices of families in areas of Pennsylvania with high unemployment.

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Eleanor Leckner came to the Long Beach health department in 1951 as public health nursing supervisor, also her title during the 4 previous years that she was with the Community Health Service of Minneapolis. She joined this agency as staff public health nurse after graduating from the University of Minnesota in 1942 with a nursing diploma and a Bachelor of Science degree.

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How much do the values of young people coincide with those of their parents?

THE REBELLIOUS YOUTH SUBCULTURE—A MYTH

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ADOLESCENCE in American society is often described as a period of rebellion against parental norms and rejection of traditional attitudes and values. A social counterpart to individual discontent is said to be represented by a distinctive youth subculture which channels and reinforces the rebellion of the individual. However, there is a large body of research findings which does not support the rebellion image as the characteristic or most widespread pattern of adolescent behavior. It is the task of this article to present a small part of the relevant research and to then discuss first, why the rebellion image exists, and second, some detrimental consequences resulting from the persistence of the myth.

Research Evidence

The degree to which adolescents see parents as significant in their lives can be a convenient starting point for examining the empirical findings against a rebellious youth subculture. In a study of 4 Minnesota rural high schools, 506 students were asked who was the most important reference point in their lives—family, school chums, or someone else. Somewhat over three-fourths indicated parents; school chums accounted for less than 10 percent of the answers.[1] The same high incidence of perceived importance of the family on personality development was reported by Oklahoma college freshmen.[2]

These studies are in accord with what has been found by outside observers who have noted the correlation of beliefs, attitudes, and practices between generations. For example, it has been found that nationally the political attitudes of lower income and upper income family teenagers closely follow the voting patterns of counterpart adults.[3, 4] Congruity also appears in more rigorous data comparing children and parents directly. In this regard, a study of 1,088 students in 13 different colleges found that most of these young people, particularly the females, conformed to the religious ideologies of their parents.[5] Investigations of participation in formal organizations by approximately 2,000 New York families found that if parents are active in organizations, their children will also tend to be participators. Where parents are nonparticipators, their children usually show the same pattern.[6]

The particular family situation can even override otherwise strong predisposing factors. In orientation to education, persons of lower socioeconomic status usually are unsympathetic to the school. But, in a study of high school dropouts in a midwestern

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Based on a paper prepared for the National Conference on Problems of Rural Youth in a Changing Environment, sponsored by the National Committee for Children and Youth.

city it was found that while only 13 percent of the lower class parents whose children dropped out of school opposed the adolescent's leaving, a group of students matched for social class and IQ who stayed in school showed 68 percent of the parents strongly insisting on attendance.[7]

Perception of Parents

While parents may be vitally important in determining their children's behavior, it could be that this influence is coercive. The perceived importance of parents could indicate that rebellion, although tried, is unsuccessful. To examine this possibility, data are required which bear on the "favorableness" of the adolescent's perception of his parents, and by inference his felt need to rebel.

A study of 3,000 Minnesota adolescents and preadolescents centering on the descriptive terms supplied by them to a sentence completion test of the order, "My father is __________," found that both boys and girls expressed overwhelmingly more favorable than unfavorable attitudes toward their parents.[8] Another study revealed that youth were willing to ascribe even more favorable traits to adults than were their parents.[9]

Studies of rural Pennsylvania high school sophomores in 1947 and 1960 assessed the acceptability of such behaviors as drinking, smoking, school failure, use of makeup, card playing, divorce, dancing, dating, use of money, and church attendance. In both time periods it was found that the youth were most likely to evaluate their parents' points of view toward these actions as "sensible" rather than as "too critical" or "not critical enough." This appraisal of the family's orientation was by far the mode.[10, 11] Thus it would seem that the value positions of youth and adults are not in serious conflict. Indeed, the data imply value congruence between generations.

The similarity in points of view between peers and parents is particularly vital when interpreting the research which shows the characteristic "withdrawal" of adolescents from family-centered and family-attended activities. Participation in academic and extracurricular school activities usually means physical withdrawal from the family and high exposure to peer influence. However, this need not mean rejection of parental norms. The test of the importance of norms lies in the ability to direct behavior without the literal presence of others for enforcement; in other words, when they have been internalized by the individual. In the Pennsylvania study cited previously,[11] as youths increased their involvement in school functions, the proportion of "sensible" answers for the family's attitudes went up, not down, as would be expected if physical withdrawal decreased the saliency of parental norms.

The similarity in values between adults and youth should not imply that disagreements are lacking. On the contrary, in specific decision-making situations what an adolescent's parents believe he "ought" to do and what his peer group thinks would be appropriate behavior may differ. When this happens the question can be raised: Which group does the individual follow? Students in 10 midwestern high schools were asked which would be the hardest result "to take" if, in joining a school club, parents disapproved of it, the teachers were negative, or it required breaking with one's closest friend. Even though the nature of the question seems to carry a bias toward obtaining the last alternative, parents still receive a majority vote. About 53 percent of the boys and girls said parental disapproval would be the hardest to take while 43 percent said breaking the friendship would "count" most.[12]

Another study conducted among girls in 7 Georgia and Alabama high schools inquired into 12 specific situations, such as which of 2 dresses to buy and whether or not to report a boy whom one saw damaging school property. The stories which conveyed the situation also indicated what alternative the parents urged and what behavior the peer group desired. The students were then asked what they would do. The tests were readministered after 2 weeks and the peer group and parent expectations were switched. Fifty-seven percent of the students' responses did not change between the first and second testing. Of the 43 percent which changed, a majority altered "what they would do" to the parental urging in 9 of the 12 situations. Two of the three situations where the shifts in answer went toward the peer group more often than parents involved matters of dress.[13]

This pattern of relative importance of peers and parents is certainly not always true. Perhaps the best generalization is that there is a flux in reference points depending on the situation.[14] However, the setting would seem rare where the parental wishes are totally ignored. Indeed, if there is to be continuity between generations, there must be some sharing of basic values between adults and youth. That such continuity exists is shown by the simple fact that American society has survived over time. Moreover, "there is remarkable agreement as to what American values are or have been and agreement upon their stability through more than 150 years."[15] Such stability could hardly be evidenced if adolescents rebelled and rejected the basic value tenets of the preceding generation.

In summary we can profitably recall a conclusion given elsewhere:

> "The failure to find evidence of parent-youth conflict regarding what constitutes proper patterns of behavior does not necessarily mean that parents and their offspring do not disagree in regard to some—and perhaps many—questions. The adolescent seeking to establish his identity in adult society may disagree with his parents regarding when recognition of his maturity should occur. He may wish to engage in activities which symbolize his adulthood while his parents feel that he is still too young. This type of 'rebellion' is as temporary as is the period of adolescence itself, and, rather than rejection of parental norms, it is perhaps better characterized as acceptance of and eagerness to participate in the larger society. Once the youth is accepted as a member of the adult society, this type of conflict ceases. It is this disagreement with parents concerning the adulthood of the adolescent which is probably responsible for the popular image of rebellious youth. However, this cannot accurately be described as a group rejection of societal norms. It constitutes an individual resistance to specific authority patterns."[10]

Of course, this kind of "rebellion" is important. It is often painfully experienced by both parent and child. It can lead to tragic results in some cases—neurosis, delinquency, even suicide or murder. It helps bring teenagers together in their cliques, friendship groups, and wider modes of affiliation and helps to hold them together as a unit. But, such conflict occurs *within a value framework* and not characteristically *over values.*

Why the Myth?

In light of the foregoing review, the question arises: Why does the myth of a rebellious youth subculture exist? It may be that at least part of the explanation lies in the conceptual framework implicitly or explicitly used to understand "culture."

The meaning of culture, and in turn subculture, is not standardized in the social sciences. Among many professionals interested in the study of human behavior, culture is equated with *all* aspects of man's social actions. Wearing blue jeans and black leather jackets, listening to Elvis Presley or Pat Boone, drinking beer or chocolate milk shakes—all are taken as equally indicative of, and caused by, one's culture. It is implied that men, through their group affiliations, have defined for themselves correct or appropriate behavior for every phase of life and for all situations. Thus, whatever the individual does is due to his meanings, motives, and definitions of the situation—jointly summed as "his culture." If two persons in a similar setting behave differently, it is because "they have different cultures" stemming from different group affiliations.

This understanding of "culture" is one of preference in emphasis and it has considerable validity. Among other things, it underscores the idea that human behavior is socially conditioned. But, it comes close to substituting social determinism for other forms of single factor explanations. More specifically, we would suggest that this understanding of "culture" helps to explain the presence of the myth. To indicate the way this can occur requires setting out a contrasting conception of culture.

Instead of emphasizing all aspects of human behavior as "manifesting culture," the second understanding of the term is less inclusive. Thus, it is taken that: (1) culture is widely shared or held in common by the members of a society but, (2) those things which are shared are the ideals for behavior, the values or criteria by which both the ends and the means to them ought to be selected. Whether in fact actual behavior conforms to cultural standards or values is problematic. Characteristically, the ideal pattern is only approximated by actual behavior. This is so if for no other reason than that the values are *general* and action situations are *specific.*

While one can take honesty as a value, just what acts fulfill honesty are not always clear. Culture here is taken as a recipe calling for a dash of ground garlic (not ¼ teaspoon), a medium wedge of cheddar (not 8 ounces), salt to taste, and so on. The results of persons following such a recipe are variable, although the outcome is still identifiable as cheese sauce and not bouillon. This conception of culture assumes that expressed behavior is not a simple and direct reflection of cultural standards. Rather, it makes room for genetic and physiological differences in personality; allows that physical conditions influence behavior; and recognizes that factors such as the size of groups, their number, and heterogeneity all help to determine human action.

The distinction between these two conceptions and their outcomes can be clarified by taking science as an illustration of a culture. Under the first usage a cultural description of "science" would emphasize, for example, the total array of the physicist's behavior—his use of electron microscopes, his precise measurement techniques, rigorous experimental setups, and so on. Turning to sociology, the "culture" of science shows a vastly different set of behaviors and characteristics. For the sociologist there are no machines comparable to electron microscopes, he utilizes relatively imprecise measurement, and he has few laboratory experiment set-ups. Therefore, one is tempted to see two different and, indeed, even conflicting cultures.

Culture as Values

In particular actions, the physicist and the sociologist are widely separated. Yet it can be shown that in basic principles they are in agreement. Both sociology and physics subscribe to the same canons for ascertaining truth, particularly the acceptance of the validity of sense data. The second conception of culture emphasizes this essential unity by seeing science *not in terms of particulars and specifics*—which can vary widely—but in terms of the basic values it adheres to in arriving at truth. These values clearly distinguish science from other types of "culture;" for instance, religion with its characteristic emphasis on revelation. The point is that people can vary in the details and particulars of their behavior without that difference necessarily signifying conflict over, or rejection of, underlying principles or values.

Similarly, the behavior of adolescents in American society differs from that of adults. Teenagers' mode of dress and grooming is sometimes radical and given to fads. They have their own magazines which cater to adolescent tastes and reflect their concerns. Among these are such problems as acne, incompetence in interpersonal relations, and knowledge of the opposite sex. Movies, popular music, and radio seem to be their virtual monopoly. The automobile has a crucial and, all too often, a deadly role to play in their lives. Dating provides a mechanism for heterosexual play and experimentation in erotic styles and is a dominant focus of attention and of time consumption. Their vocabulary is sometimes strange to adult ears.

However, the differences in adolescent and adult behavior, while real, are differences in degree rather than in kind. And the degree of dissimilarity has often been overstressed. Adult garb shows yearly change. Dale Carnegie has made a fortune through correcting adults' "shyness," and cosmetics have a tradition of hiding nature's "flaws." The fanfare given Detroit's latest models, the 5 or 6 million new cars sold annually, and the father's usual pride in showing off his new purchase to the neighbors are commonplace. Kinsey's reports, divorce court scandals, and the ever-present aura of sexuality in advertising aimed at adults suggest that cross-sex interest and variety in erotic play does not wither with youth. Adults, too, have their specialized "languages" stemming from their work.

If one ignores the basic similarities between adolescents and adults and emphasizes culture as the "particulars" of behavior, then disagreements and differences at the level of specific action may be misinterpreted and assumed to apply to the general value framework as well. As has been mentioned, however, research has pointed to the fact of congruity between generations. In stressing the similarity in values, in the second sense of culture, one does not say that knowing whether singer X or singer Y is currently in favor at a particular school or in a given town is unimportant. It may be crucial knowledge in gaining and keeping rapport with teenagers. By concentrating on the idiosyncratic aspects of adolescent behavior, however, one can miss the similarity in values between adults and youth. Failure on the part of many writers to distinguish between the two understandings of culture and the resulting tendency to see conflict between youth and their parents in *all* areas of behavior because differences exist in some activities may at least partially explain the presence of the rebellious adolescent subculture myth.

Moreover, viewing the period of adolescence primarily in terms of a distinctive, rebellious subculture can hinder understanding of many aspects of youth behavior. We shall take, as one example, the problem of school dropouts.

School Dropouts

Focusing on the "rebellion" of the adolescent and implying as this does the discontinuity of values between generations tend to underestimate the difficulty of changing the potential dropout's orientation so as to keep him in school. By viewing the individual as "in rebellion" the image is cast that such a person is adrift. If the teenager has "rejected" his parents, then he will be looking for new anchorages. Thus, the task of keeping the potential dropout in school appears to be a matter of merely presenting and "selling" the values that will make him see the advantages of this course of action. But the notion of youth adrift through rebellion ignores the possibility that there may be stringent competition with the proposed values. By ignoring the fact of continuity in culture, one can be led to miss the simple fact that there is often parental support for the dropout adolescent's decision—support which may be tacit but nonetheless present. That is, some parents tend to see little utility in a secondary education and may openly encourage, or at least reinforce, the youth's choice to leave school. As a result, any attempt to change values must take into account the possible familial buttressing of teenage decisions.

We need to recognize that the adolescent who drops out of school may not be adrift in a rebellious youth subculture. He can, in fact, be closely tied to the relatively stable cultural background of his parents and may leave school prior to graduation because of this very fact. The problem of changing values and influencing these young people to stay in school is not, therefore, a short run task, or is it an easy one. The matter is not as simple as throwing a life preserver to a drowning sailor, for the persistent fact remains that persons often reject such "help" when it is not supported by their social and cultural environment. The limited success of slum clearance projects, educational retraining programs, and efforts to rehabilitate criminals are cases in point. The problems of high school dropouts would seem to be similar. Any remedial program hoping for dramatic gains must be total, involving not just the individual, but his family and perhaps the general community as well. The rebellious youth myth can cause us to overlook this simple but vital fact.

The conception of a rebellious youth subculture emphasizes the generational split as the most important and, hence, directs attention primarily to the age-youth cleavage. It implies that all teenagers can be considered as members of a homogeneous unit standing in opposition to parents. Such a position tends to ignore the variability *among* young people—variability which is crucially important in understanding school dropouts.

Social Class Differences

One line of important differentiation is a distinction based on social class or socioeconomic status. Research has shown that there are many things involved in a student's leaving school prior to graduation, but the single factor most persistent and widespread in its relationship to early withdrawal is social class position or socioeconomic status.[16] These studies indicate that lower socioeconomic class adults generally place less value on formal education than do middle and upper class persons. This devaluation of school attendance on the part of the adult population is often, in turn, reflected in the adolescent's own decision to withdraw prior to graduation. Such a person manifests a decision which is frequently anchored in the value system of his originating culture. Rather than some sort of rejection of the parentally sponsored norms, the act of dropping from school may represent an affirmation of them.

At the same time one ought to be aware that:

> ". . . action oriented to the achievement and maintenance of the lower class system may violate norms of middle class culture and be perceived as deliberately nonconforming or malicious by an observer strongly cathected to middle class norms. This does not mean, however, that violation of the middle class norm is the dominant component of motivation; it is a by-product of action primarily oriented to the lower class system. . . . a distinctive tradition many centuries old with an integrity of its own." [17]

Such an idea, of course, runs counter to many persons' conception of lower class culture. Indeed, until quite recently it was fashionable to picture lower class society as unstable, disorganized, and hence exhibiting little continuity from generation to generation. To support this notion writers pointed to, among other things, the high incidence of "broken" homes composed of only mother and children. This is at variance with a normal middle class family in which a father is present. It does not mean necessarily that the mother-child family lacks viability. The contrary is true. For example, the lower class family form in which the father is absent has shown amazing persistence through time. One need not condone this type of family unit nor ignore the possible behavioral outcomes for the children involved, to see its vitality. The person who wishes to change social structure or the values substrating it must start with a recognition of reality and not from his own wishes about it or conclusions drawn from a middle class sense of "correctness." In terms of the values of the potential dropout, the first step in this process is to appreciate the wide variation existing within the grouping, "adolescents."

While social class differences represent perhaps the most striking case of important variability, others also occur and need emphasis. We have stressed class because it is a vital element. However, our discussion should not be taken to mean that no lower class youths finish high school. They do. "There is a sizeable proportion of the lower class group who do not incorporate this [a lower class] value system." [18] We know that parents serve as mediators to the larger cultural milieu and thus particular familial considerations, such as parental encouragement to finish school or to aspire to high status positions, may overcome the effect of typical lower class devaluations of education.[19] We do not know enough, however. What creates the situation for general parental support for high aspirations?

The fact that there are some lower class persons who highly value education represents a challenging problem. If the factors causing these persons to reject devaluation of education can be identified, we may be able better to direct other lower class adolescents toward similar goals. In this cause a flexible conception is required which can not only allow for the variation that is lower class culture, but which can see variability within the lower (or other) class itself. Unfortunately, the rebellious subculture idea does not foster recognition of any such differentiation.

The idea of varying and possibly competing values needs emphasis not only because of the stress which can result for the target of the change program, but also because it presents certain personal conflicts for the individual who is interested in bringing about change. Most change agents, reflecting the dominant middle class values of American society, tend to see no problem as unyielding in the face of simple educational effort. But values represent basic criteria of worth, and, hence, are not easily changed nor readily amenable to compromise. Therefore, any action program designed to keep teenagers in school is potentially fraught with conflict, for it requires altering the potential dropout's values. Furthermore, this goal transgresses one of the basic value premises of the change agent's own cultural background—the belief that one ought to "live and let live." Since he may be unable or unwilling to accept the possibility of open conflict, it gives him some reassurance to believe that the dropout adolescent is adrift and desires his help. This is often not the case, but the idea of rebellious youth salves one's conscience, eases anxiety, and makes a difficult job appear easier than it is. Perhaps these functions of the myth also help to preserve its existence.

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[1] Rose, Arnold M.: Reference groups of rural high school youth. *Child Development,* September 1956.

[2] Ostlund, Leonard A.: Environment-personality relationships. *Rural Sociology,* March 1957.

[3] Remmers, H. H.; Radler, D. H.: The American teenager. Bobbs-Merrill, Indianapolis, Ind. 1957.

[4] Lipset, Seymour M.: Political man. Doubleday & Co., Garden City, N.Y. 1960.

[5] Putney, Snell; Middleton, Russell: Rebellion, conformity, and parental religious ideologies. *Sociometry,* June 1961.

[6] Anderson, W. A.: Types of participating families. *Rural Sociology,* December 1946.

[7] Havighurst, Robert J.; Bowman, P. H.; Matthews, Gordon B.; Pierce, James V.: Growing up in River City. John Wiley & Sons, New York. 1962.

[8] Harris, Dale B.; Tseng, Sing Chu: Children's attitudes toward peers and parents as revealed by sentence completions. *Child Development,* December 1957.

[9] Hess, Robert D.; Goldblatt, Irene: The status of adolescents in American society: a problem in social identity. *Child Development,* December 1957.

[10] Bealer, Robert C.; Willits, Fern K.: Rural youth: a case study in the rebelliousness of adolescents. *The Annals of the American Academy of Political and Social Science,* November 1961.

[11] Wilson, Paul B.; Buck, Roy C.: Pennsylvania's rural youth express their opinions. Pennsylvania Agricultural Experiment Station Progress Report No. 134. 1955.

[12] Coleman, James S.: The adolescent society. The Free Press of Glencoe, New York. 1961.

[13] Brittain, Clay V.: Adolescent choices and parent-peer cross-pressures. *American Sociological Review,* June 1963.

[14] Solomon, Daniel: Adolescents' decisions: a comparison of influence from parents with that from other sources. *Marriage and Family Living,* November 1961.

[15] Kluckhohn, Clyde: Have there been discernible shifts in American values during the past generation? *In* The American style. (Elting E. Morison, ed.) Harper & Bros., New York. 1958.

[16] Blough, Telford B.: A critical analysis of selected research literature on the problem of school dropouts. Unpublished dissertation. University of Pittsburgh, Pennsylvania. 1956.

[17] Miller, Walter B.: Lower class culture as a generating milieu of gang delinquency. *Journal of Social Issues,* Vol. XIV, No. 3, 1958.

[18] Hyman, Herbert H.: The value systems of different classes: a social psychological contribution to the analysis of stratification. *In* Class, status and power. (Reinhard Bendix and Seymour M. Lipset, eds.) The Free Press, Glencoe, Ill. 1958.

[19] Simpson, Richard L.: Parental influence, anticipatory socialization, and social mobility. *American Sociological Review,* August 1962.

Will those who still feel uneasy [about the sit-ins] try to recall what those Bostonians were doing in 1773 when they tossed that famous tea in the harbor, and remember that unborn generations gave the act a momentous place in American history. They sought a cup of untaxed tea! The students seek a cup of unsegregated coffee.

Whitney Young, Jr., executive director, National Urban League, to the 1961 forum of the National Conference on Social Welfare.

RACIALLY INTEGRATING A STATE'S TRAINING SCHOOLS

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IN JULY 1960, the Circuit Court of Baltimore City, Md., committed a 13-year-old Negro boy to a public institution which had previously been serving white delinquent boys only. This court action led eventually to the racial integration in 1961 of all four Maryland State training schools for juvenile delinquents.

Following the 1954 opinion of the Supreme Court of the United States declaring segregation of public schools unconstitutional,[1] State correctional agencies administering racially segregated training schools for juvenile delinquents raised questions as to whether the Court's opinion applied also to these institutions. Officials in States opposing the change contended that it did not apply because institutions for delinquents were correctional rather than public educational in nature or were residential rather than nonresidential public educational facilities; and that the difficult task of rehabilitating delinquent children in public institutions would be greatly aggravated by mixing white and Negro children.

The question relative to the correctional rather than educational nature of training schools was answered by an opinion of the Maryland Court of Appeals, to be discussed in this article. The question of the extent to which the rehabilitation of delinquent children would be aggravated by mixing the races in State training schools continues to be raised. However, officials of the 177 public institutions serving delinquent children on a racially integrated basis in 1962 have not indicated that any major problems of supervision and programing have resulted directly from interracial groupings.

These 177 institutions represent a 16-percent increase over the number of racially integrated public institutions for delinquents in 1953. Nevertheless, 53 such institutions were still completely segregated in 1962.[2]

Since 1951, Kansas, Missouri, Delaware, West Virginia, Texas, North Carolina, Kentucky, and Maryland have changed State institutional policies and practices, for the first time bringing together delinquent children from the two major races either in the educational programs during the day or on a fully integrated 24-hour basis.

This article will describe how the southern border State of Maryland made the transition.

Until the Baltimore City Circuit Court's commitment of the first Negro boy to the formerly all-white Maryland Training School for Boys, the State of Maryland operated four segregated training schools for juvenile delinquents. Article 27 of the Annotated Code of Maryland (1957 edition) contains four sections. Section 657 identifies Boys' Village of Maryland as a public agency for the care and reformation of "colored, male, delinquent minors." Section 659 limits admission to the Maryland Training School for Boys to "white, male, delinquent minors." Section 660 identifies the Montrose School for Girls as the State training school for "white, female, delinquent minors." Section 661 refers to the Barrett School for Girls and restricts admission to "colored, female, delinquent minors."

In 1943 the legislature had transferred the administration of these four training schools from the State Department of Education to the State Department of Public Welfare stipulating, however, that the State superintendent of schools would carry responsibility for lending assistance to the welfare department in developing the educational programs within the training schools.

The State Board of Public Welfare long has been interracial in composition. Its nine members are appointed by the governor. Each training school also has a nine-member board of managers, also appointed by the governor. These boards in turn appoint the superintendents of the training schools. Until 1961 these boards of managers were racially segregated although not by law.

Shortly after the 1954 Supreme Court decision on school segregation, the Maryland State Board of Public Welfare requested an opinion from the State's attorney general as to whether the decision applied to the State's four training schools. The attorney general ruled that the State Board of Public Welfare could not as an administrative agency in the executive branch of State government proceed to integrate the training schools racially because an element of doubt existed as to whether these institutions could be properly classified as educational rather than as correctional facilities. Any changes, he explained, would have to be made either by the courts or the State legislature.

Unsuccessful attempts were then made by the Board and by the director of public welfare to have enabling legislation passed by the Maryland General Assembly. The House of Delegates passed enabling bills, but the State Senate would not concur.

Related Developments

Several other developments played an important part in the eventual racial integration of the training schools. Because the training schools were seriously overcrowded, the Board and the director of public welfare had decided to act as quickly as possible on many of the recommendations regarding the training schools contained in a 1953 report made by the Commission on the Administrative Organization of the State.[3] This commission had conducted a full study of delinquency control in Maryland.

A major finding of the Commission served as a springboard for action by clearly delineating the difficulty each training school faced: ". . . with some children committed indefinitely and others temporarily detained, ranging in age from 8 to 19, in experience from innocence to vicious sophistication, in intelligence from low feeblemindedness to brilliance, in personality from well-adjusted to near psychotic, much effort at treatment in Maryland's training schools is wasted." Pointing out that "a diversified treatment system that can reclaim maladjusted children calls for long-range planning" the Commission recommended the preparation of such a plan.[3]

Acting on this recommendation the Board in 1955 persuaded the governor to establish the first Maryland Commission for the Prevention and Treatment of Juvenile Delinquency. This commission formed a subcommittee on institutions charged with preparing recommendations. This interracial committee was composed of lay and professional leaders from the fields of law, social work, corrections, industry, mental health, education, and religion. It recommended that Maryland's four training schools and other public and voluntary institutions serving delinquent children be classified to serve children on the basis of their individual treatment needs and that race be discarded as a placement criterion. This recommendation was in line with the position of the U.S. Children's Bureau:

> **"A comprehensive and coordinated network of facilities and services for the rehabilitation of a State's delinquent youth is important if the social well-being and general welfare of this group is to be achieved. . . . Ideally, in addition to basic child welfare services, these would include detention facilities, diagnostic study centers, small residential treatment centers for seriously disturbed children, facilities for various age and coeducational groupings, foster homes, group homes, and forestry camps."**[4]

In developing a long-range plan for expansion and diversification of its institutional facilities, the Board specifically provided for utilization of the training schools on a racially integrated basis, pointing out that the segregation policy made it impossible to diversify the State's correctional program on the basis of the individualized treatment needs of delinquent children.[5] This plan had the support of the governor, the Maryland State Department of Planning, and the State Department of Education and led to the abortive attempt to get the State training school laws changed.

In the meantime, the Board in 1955 began to apply the diversification principle by securing approval from the governor and the legislature to establish the State's first forestry camps for older boys. In

1958, two additional forestry camps were constructed and in 1959, a detention-diagnostic center. These facilities have from the beginning been operated on a racially integrated basis since the laws creating them make no mention of segregation.

Court Actions

A series of court actions preceded the placement of the first Negro boy in the Maryland Training School for Boys. These began in October of 1959 when the boy appeared before the Circuit Court of Baltimore City charged with being a delinquent. The court adjudged the boy to be a delinquent and announced that he would be committed to a State training school. Counsel for the boy moved that the court issue a declaratory decree on the constitutional question of whether he could be committed to the Maryland Training School for Boys rather than to Boys' Village.

In the motion, counsel stated that the State training school laws which segregated delinquents on the basis of race were unconstitutional and that the welfare and best interests of the boy would be served if he were committed to the Maryland Training School for Boys, heretofore restricted to white boys only. The circuit court granted the motion and continued the juvenile proceeding in order to provide time for the attorney general, representing the State Board of Public Welfare, and counsel for the boy to file briefs and to prepare for a hearing.

At this hearing, which took place in the spring of 1960, both the attorney general and counsel for the plaintiff summoned a large group of witnesses. Included were the chairman of the State Board of Public Welfare, the chief of the division of training schools, the superintendents of the institutions, and other officials. The attorney general contended that the training schools were not bona fide public educational institutions but were residential institutions for children who had been adjudged delinquent after committing offenses which would be classified as felonies if committed by adults. Counsel for the plaintiff contended that the training schools *were* public educational institutions and that the State training school laws violated the equal protection and due process clauses of the 14th amendment to the United States Constitution. Counsel also maintained that separate State facilities for the care and treatment of delinquent children were detrimental to the educational, psychological, and social rights of Negro children.

On July 6, 1960, in a declaratory decree, the Circuit Court of Baltimore City held that the sections of the Annotated Code of Maryland which "required separation of the Negro and white races in the four training schools violated both the equal rights and the due process clauses of the 14th amendment to the United States Constitution and are, therefore, unconstitutional." The court further "declared and decreed that it could not select a training school to which a minor is to be committed on the basis of the minor's race or color.[6] On the same day, the court, in a separate juvenile action, ordered the boy committed to the Maryland Training School for Boys.

The State Board of Public Welfare, through its counsel, the attorney general, appealed the declaratory action to the Maryland Court of Appeals. Responsible for administering the State training school program within the framework of State law, the Board took this action on the theory that a thorough legal test in the courts was necessary before it could proceed with its plans for operation of all the training schools on a racially integrated basis.

It was the Board's understanding that the full integration of the four training schools could not be effected on the basis of the action of the Baltimore City Circuit Court; that only on a case to case basis, with litigation, could Negro children be placed by the courts in white schools and white children in Negro training schools. The attorney general prepared the brief for the State. The case was argued before the full court of appeals in the fall of 1960 in the State capital Annapolis.

In its opinion, handed down on February 7, 1961, the Maryland Court of Appeals affirmed the lower court's decree but modified it to include only the Maryland Training School for Boys.[7] Rejecting the argument that as a residential facility serving children adjudged delinquent the training school was correctional rather than educational in nature, the court found that the provision of an educational program put the training school in the classification of a public educational institution.

Since the opinion of the high court dealt with only one of the four training schools, the State Board of Public Welfare immediately solicited a formal opinion from the State law department on whether or not the ruling applied to the three other training schools. The Board also asked for clarification as to its powers regarding the establishment of admission policies for the four training schools and for transfers between the training schools.

In an opinion dated February 28, 1961, the attorney general advised that the action of the court of appeals applied to all the training schools since the Maryland Training School for Boys was a "State facility identical in operation to that of Boys' Village, Barrett School for Girls, and Montrose School for Girls. There being no natural distinction between these institutions, it necessarily follows that none of them as presently constituted can continue in operation on a racially segregated basis."

The attorney general also advised that the State Board of Public Welfare *could* establish admission policies in respect to chronological ages for each of the four training schools, which the courts would follow in committing delinquent children. The opinion also dealt with the transfer powers of the Board, making a distinction between children committed to the department and those committed by the courts directly to one of the four training schools. The attorney general ruled that in the latter instance under Maryland law the committing court would have to be advised of any approval and transfer.

Following this opinion, the State Board of Public Welfare proceeded to put into execution its plans for the orderly racial integration of the four training schools.

Administration and Reclassification

Preliminary planning for the desegregation of the four training schools had been drawn up as early as 1957. These were now further developed by the staff of the State Department of Public Welfare, under the leadership of the department's director and the State Board of Public Welfare, and with cooperation from the State Department of Education, the superintendents and boards of managers of the training schools, the courts, and consultants from the U.S. Children's Bureau.

Information had already been gathered on the characteristics of the children at the four training schools [5]—their chronological age at admission, place of residence, educational achievement scores, intelligence level, previous delinquency involvement, family status, education, employment status, legal status, and related social and psychological factors.

A full analysis was conducted of the actual population experience at the four training schools for a 10-year period. The length of stay or movement of the children through the training schools was also studied. On the basis of these studies, population projections were prepared which established the basis for identifying what new facilities were needed.

The problem of classifying the two State training schools for delinquent girls did not prove to be difficult. The majority of Negro girls committed to Barrett School for Girls came from Baltimore City. Since the upper jurisdictional juvenile delinquency age in Baltimore City was 16 years, Barrett School for Girls had actually been serving younger girls on the average than the all-white Montrose School for Girls, which received fewer girls proportionally from Baltimore City than from the 23 Maryland counties where the upper juvenile court age is 18. In addition, the physical plant of the Barrett School for Girls was smaller and the program lent itself to a treatment program for preadolescent girls.

Therefore, in its official admission criteria for Barrett School for Girls issued to the courts on March 22, 1961, the State Board of Public Welfare classified this institution as the Maryland State training school for girls 13 years of age and under. The courts were given some discretion, however, to commit 14-year-old girls found to be physically and psychologically immature and in need of highly specialized remedial services, particularly those which were educational and clinical in nature.

Besides having a larger physical plant and a staff more experienced in dealing with older girls, the Montrose School for Girls had educational facilities which made possible more depth in vocational training. The Board, therefore, classified the Montrose School for Girls as the training school for girls 14 years of age and older.

The classification of the State training schools for boys was more difficult. In addition to the training schools, the State Board of Public Welfare operated forestry camps for boys and diagnostic-detention centers, and was planning new institutions. Moreover, the boys' training schools were much larger in size than those for girls.

Fortunately, the Maryland Training School for Boys had developed its physical plant in such a way that there were two separate campus sections, each with an assigned capacity for nearly 200 boys and each with educational facilities. These had been designated by the management as junior and senior schools. Since the junior school had already developed a program for younger boys, the State Board of Public Welfare classified this part of the Maryland Training School for Boys as a junior school for boys 12 years of age and under and for physically and psychologically immature 13-year-old boys. The Board in its admission criteria specified that boys committed to this institution be in need of an all-day special educational program and specialized clinical treatment services.

The Board decided that Boys' Village of Maryland was better equipped to serve boys at the preadolescent level of development. Therefore, it drew up the following admission criteria:

1. Physically and psychologically mature 13- and 14-year-old boys.
2. Male recidivists 13 years of age or older.
3. Boys in need of an all-day specialized educational program with emphasis on industrial training in shop settings.

For boys 15 years of age and older, the Board decided to utilize the senior school at the Maryland Training School for Boys and the forestry camps. The senior school was classified for boys 15 years of age and older, for male recidivists 14½ years of age and older, and for boys in need of special educational programs accenting vocational rather than academic training.

The Board designated the forestry camps for boys 15½ years of age who gave evidence that they could benefit from a camp experience and that they would not present a major security risk in an open camp setting.

After these classification decisions were made the director and professional staff of the department of public welfare and the institutions conferred with the judges of various courts to acquaint them with the admission criteria and explain the manner in which institutions would function. Both individual and group conferences were held with the assistance of the administrative office of the courts. In addition each court was supplied with copies and explanatory statements of the admission policies. The Board determined that the new admission policies would be effective in 90 days, or on July 1, 1961, and the courts were so advised.

Because the staffs as well as the student bodies of the four institutions were to be racially integrated, it was necessary in the 90-day period to recruit white staff members for the two training schools which were formerly all Negro. In this period also a special staff training project was carried out with the help of an intergroup committee of the Baltimore Health and Welfare Council. This interracial group spent considerable time at two of the State training schools working with superintendents and staff prior to and after their actual integration. Special staff training was also provided regarding the educational programs of the institutions.

By January 1, 1962, integration of the training schools was well under way. In following the training school admission criteria established by the State Board of Public Welfare, the committing courts proved to be extremely cooperative and generally supportive of the integration plans. No direct questions were raised about the advisability of the plan though there were some expressions of concern about the effect the change would have on the institutions' educational and treatment programs.

Effects and Implications

The racial integration of the Maryland State training schools had both immediate and long-range effects. Some were easily observed while others were of a much more subtle nature.

Segregationist groups in the community expressed alarm at the mixing of the races, particularly Negro girls with white girls, but community leaders were generally supportive. The reactions in the communities immediately adjacent to the training schools ranged from open protest to commendation.

The attitude of the parents and relatives of children committed to the training schools was generally marked by their acceptance of the change. Some parents of white children, however, protested the presence of Negro children in the same groups with white children.

Concern that the children themselves would react negatively to the major change in admission policies proved to be unfounded. In the cottages, which for the first time contained both white and Negro children, some minor behavior incidents occurred in the initial phase of adjustment. Cottage staff usually used these incidents as opportunities to talk to the children about the superficial meaning of differences in physical appearances. The key to smoothness of the integration process was found to be the type of person or couple supervising the young people in the cottage.

The effect upon institutional staffs included minor rebellions and a few resignations. However, after the courts began committing children on the basis of their ages and treatment needs, there was general staff acceptance of the new policies at all levels. The superintendents were particularly effective in carrying staff through this period and in working with the department in setting up special staff training programs. However, the employment of white teachers, cottage parents, and shop instructors for the two training schools which previously served Negro children only proved to be slow and difficult. Some voluntary transfers within the training schools occurred, but generally staff integration was eventually accomplished by the means of employing new staff members.

The boards of managers of the four training schools responded quickly and joined with the State Board of Public Welfare and the director of the department in formulating plans for the integration. These boards of managers played a major role in all the conferences and deliberations, including those to integrate these racially segregated boards, an early step in the entire integration plan.

The most pronounced effect of the racial integration was upon the training school educational programs. Instead of being faced with children from ages 8 to 18, presenting multiple educational problems, potentials, and needs, the educational directors of the individual training schools were confronted with school populations which corresponded more closely to those found in the traditional elementary, junior and senior high schools in the community, and could plan the curricula accordingly.

Other programs affected by the change, but in only a minor degree, were the medical care, psychiatric, psychological, social work, religious, recreational, maintenance, and related programs. The effects of these programs had to do largely with adjusting the facilities and training the staff to deal with children of the specific age groups to be served by each institution.

In the last analysis, the most significant effect of the racial integration of the Maryland training schools may be the addition it has brought to the body of legal precedents against segregation of public facilities. In view of the decisions of the Supreme Court of the United States, the Maryland Court of Appeals, and other courts, it is extremely doubtful if racial segregation of training schools or other public institutions serving delinquent children in any of the States operating them can survive a court test. If the executive, legislative, and judicial branches of State government provide the leadership, many of the southern States can look forward to the opportunity to utilize more effectively their public institutions serving delinquent children by diversifying them on a treatment rather than a racial basis.

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[1] *Brown et al.* v. *Board of Education of Topeka et al.*, 347 U.S. 483 (Kansas).

[2] Gant, Duplain R.: Statistics on public institutions for delinquent children, 1962. U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB statistical Series No. 70. 1963.

[3] Commission on the Administrative Organization of the State: The administration of juvenile delinquency control in Maryland; 11th report of the Special commission. February 1953.

[4] U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: Institutions serving delinquent children—guides and goals. CB Publication No. 360. Revised 1962.

[5] Maryland State Department of Public Welfare: Institutional facility needs—10-year development program. May 5, 1960.

[6] Circuit Court of Baltimore City: Declaratory decree docket—A 142, File A-4005. *Baltimore Daily Record*, July 6, 1960.

[7] *State Board of Public Works et al.* v. *Robert Myers* (Minor etc.), 167 A. 2d 765.

In the training schools I visited {in Africa} I was struck by how much more easily and simply, without enforcement, reeducation is carried out there than it is in Western countries. The reason is that the African delinquent child finds in the institution a way of living and a discipline that is much nearer to the tribal discipline, with its background of respect and obedience, than the Western conception of institutions is to the nuclear family's way of life. There is less danger in African training schools that the children have two codes of morals, as they often do in Western institutions: one for their own use, and another which they accept superficially just to fit in with the institution's rules and policy.

Dan Q. R. Mulock Houwer in **News Letter of the International Union of Child Welfare, *March–April 1961.***

Some social signs of abusive parents are helpful in efforts . . .

TOWARD PREVENTION OF CHILD ABUSE

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THIS PAPER is written on the premise that constructive, preventive intervention in the cycle of violence and punishment is necessary for preventing the physical neglect and abuse of children. Its purpose is to present the consistent social signs which our experience at the Children's Hospital of Philadelphia has led us to believe have implications for early identification of neglectful or abusive parents and for the prevention of further child neglect and abuse. Our observations of the parents suspected of causing the condition for which their children were brought to the hospital have led us to believe that in such cases chronic neglect and brutal punishment have followed down the generations, with gathering force.[1] Thus prevention implies not only protecting the child from future abuse—and possible death—but in somehow breaking the chain which so often leads the once abused and neglected child to neglect or abuse his own child.[2]

Our observations are based on two studies made at the hospital: the most recent, of the case records and followup of 33 severely neglected or battered children from 29 families; and a previous one of 23 infants and children brought to the hospital for serious "failure to thrive."[3] From these observations we have arrived at three groupings of the kinds of parents found in cases of abuse or neglect. We think that further studies and refinement of results will eventually lead to a larger number of groupings. The three main groupings are: (1) neglecting parents who are readily responsive to treatment by the hospital team; (2) neglecting parents readily responsive to a combination of hospital and community services; (3) unresponsive parents whose children are in acute danger. There is no sharp line between these groups. The criteria for classification are in fact matters of degree and have to do with:

1. The degree to which a parent's personality development permits frustration tolerance without self-disintegration.
2. The soundness of parental motivation, flexibility, and capacity for learning and assuming or resuming the role of promoting child growth and development.
3. The degree of the parent's reality testing capacity.
4. The seriousness of the child's symptoms.
5. The seriousness of the parent's reality situations.

These criteria aid in predicting margins of safety for children, in determining the use of continued hospital team services, and in determining what collaborating community services need to be called upon

An overfed 3-month-old baby with fractured legs, in a double cast. Parents who batter their children, according to the authors, are expressing parental incapacities in action language.

to protect the child. Our case material points up essential areas of interviewing for purposes of social assessment and case management no matter which classification a parent falls into. These major interviewing areas are concerned with the following questions:

1. What is a parent's own estimate of current life needs as they are filled or threatened by children's needs for care?
2. Did this parent have positive role connections with society before his parenthood?
3. What are this parent's feelings about his own childhood?
4. What are this parent's feelings about his own parents?
5. Has this parent ever identified with the nurturing parent role?
6. How strong is this parent's motivation to be connected to society by a social role? which role? as an adult "child," a worker, a parent?
7. How does this parent respond to a child's everyday needs? as natural and acceptable? as simple interference? as assaultive and oppressive?
8. Does this parent attribute irrational degrees of motivation, responsibility, and judgment to an infant or a young child?
9. Do these parents expect a child to protect *them* instead of their protecting *him?*
10. Does this parent admit any responsibility in the child's neglect and abuse?
11. Is this child held completely responsible for the neglect and abuse?

In finding answers to these questions it becomes possible to gauge margins of safety and the probability of recurrence in order to plan appropriately. They help lead the way through the maze of contradictory statements and lack of real facts which so often surround cases of seriously neglected or battered children.[4]

In our dealings with parents of seriously neglected or abused children brought to our hospital we have used a noncritical, nonpunitive approach not only for purposes of sound data collection on which to base practical plans for protecting children, but also in order to protect parents from further acting out their frustrations on their children.[5] This has been based on our recognition that parents who neglect and batter their children are actually speaking their parental incapacities in action language and are asking to be stopped in behaving as they do.[1] Why else do they bring their children to hospitals and so run a high risk of punishment? We think that parents run this risk because the risk of total, internal, personality disintegration is even more terrifying—a risk they run in continuing the care of their children.

While we have presented the guidelines for interviewing in the form of questions, we cannot stress strongly enough the importance of observation in the diagnostic assessment of the parents' child caring potential, and the disintegrating effects of direct questioning as to how the injury was incurred on parents' ability to cooperate in eliciting information or planning for their child.[1]

What specifically can be observed about parents that is helpful not only in assessing the validity of suspicions that the condition of the child brought to a hospital might have been caused by his parents' brutality or neglect, but also in gauging something of their potential for providing nurturing care to the child? From our experience with the parents of injured and severely neglected children brought to the Children's Hospital, we have been able to identify the following typical reactions and attitudes of nurturing parents and the contrasting reactions and attitudes of neglecting, battering parents.

Typical reactions and attitudes of protective parents to children's injuries:

1. Are voluble and spontaneous in reporting details of a child's illness or injury.

2. Show concern about the degree of the damage.

3. Show concern about the treatment.

4. Show concern about the possibility of residual damage.

5. Exhibit a sense of guilt. The younger the child, the more guilt the parents feel for not protecting him. Guilt and remorse are felt even when the parent has had no part in the child's injury.

6. Ask many questions regarding the prognosis of the child's condition.

7. Have difficulty in detaching from the child on admission.

8. Attempt restitution through frequent visiting, toys, and other gifts, in apology to the child.

9. Ask questions about discharge date.

10. Ask questions regarding followup care.

11. Identify with the child's feelings, both physical and emotional, when he is injured.

12. Are positively related to the child.

Some typical reactions and attitudes of neglecting, battering persons:

1. Do not volunteer information about the child's illness or injury.

2. Are evasive or contradict themselves regarding the circumstances under which the child's condition occurred.

3. Show irritation at being asked about the development of the child's symptoms.

4. Critical of the child and angry with him for being injured.

5. Give no indications of feeling guilt or remorse regarding the child's condition.

6. Show no concern about the injury.

7. Show no concern about the treatment.

8. Show no concern about the prognosis.

9. Often disappear from the hospital during examination or shortly after the child is admitted.

10. Tend not to visit the child in the hospital.

11. Seldom touch the child or look at the child.

12. Do not involve themselves in the child's care in the hospital.

13. Do not inquire about the discharge date.

14. Ask to have child home only when interrogation has frightened them.

15. Do not ask about followup care.

16. Show concern not about the child but about what will happen to themselves and others involved in the child's illness or injury.

17. Maintain that the child has injured himself.

18. Act as though the child's injuries are an assault on them.

19. Fail to respond to the child or respond inappropriately.

20. Give no indication of having any perception of how a child could feel, physically or emotionally.

21. Constantly criticize the child.

22. Never mention any good quality in the child.

23. Show no concept of the rights of others.

24. Are preoccupied with themselves and the concrete things in life.

25. Are often neglectful of their own physical health.

26. Exhibit violent feelings and behavior and in interviewing reveal that this was a pattern in their original family.

27. Reveal in the interviewing that they are concerned about having been abandoned and punished by their own parents and are longing for a mother.

28. Show overwhelming feelings that they and their children are worthless.

The following cases illustrate some of these reactions in varying degrees. The first case could be classified as Group 1—a case where in spite of considerable negatives enough positives were present for effective treatment:

Joe Green, 3 months old, **was brought to the hospital by his parents at his maternal grandparents' insistence because of severe growth failure. The 22-year-old parents also had an 18-month-old boy, who was thriving well. The Greens vented their anger with violent words on members of the hospital team, but their real anger was at Mrs. Green's mother, who treated them like adolescents but insisted that they be better parents.**

The interviewing revealed that Mrs. Green was afraid of her children and mistrusted her ability to care for them. She preferred to work and have her parents care for the babies, though this meant that she and her husband with their two children must live in one room in the grandparents' home and continue in the status of adolescents. Mr. Green worked, brought home the money, and kept out of the family fuss.

Mrs. Green visited Joe constantly. Though she fought any idea that she had any talent for aiding in his growth and development, she gradually engaged herself in Joe's care in the hospital. After the child's release she quit her job and was able to get her parents to let her family have an additional room. She brought Joe to the clinic regularly and he continued to thrive well. The wizened, hungry baby was replaced by a rounded, happy, satisfied, satisfying baby. Mrs. Green had a new look, softer, more composed, and confident. At the clinic she asked many questions and presented her own ideas about Joe's care.

Engagement in Joe's medical care enabled some resolution of the maturational crisis of these young parents. Joe was the epicenter of a family crisis. Now he is just a baby, with a mother who enjoys caring for him and a father who carries financial responsibility. Although maternal deprivation [6, 7] characterized Joe's first 2 months of life, prevention of the full force of the syndrome came early.

The next case, also with both positive and negative factors, comes from our Group II classification—cases requiring long-term conjoint community services for the development of parents' potentials:

Jane Ford, 6 years old, was having three to four epileptic seizures a night, the equivalent of several harsh beatings, when her mother brought her to the hospital. Mrs. Ford had stopped giving the child previously prescribed anticonvulsant pills, although she knew she could have received them free of charge at any time if she would only ask for them.

The interview with the social worker indicated that Mrs. Ford's concerns were not about Jane, but about her own recently deceased father who had died under mysterious, brutal circumstances; about two children she had lost to their father and his mother via a court order; about her finances, her housing, and her job. She was desperate and furious. In addition, she was physically ill although she was working at an outdoor winter job to support her children.

Mrs. Ford was in a panic, but she did not evade responsibility for Jane's condition:

"Nobody has to tell me I am neglecting Jane; I know that. I'm the one who watches her have the fits. I may not know how to be a *mother,* but I know how to give pills. . . .

"I don't remember my mother. I was dragged in and out of boarding houses by my father. Nobody could have cared less about me. I could always depend on my father if I had to. I was tough. I fought them all. But now I know I need help. I know Jane needs pills, but I don't know how to ask for them, and I don't know what *I* need."

The hospital team helped Mrs. Ford to assume consistent, constructive use of medical care for herself and Jane. Later she asked voluntarily for medical care for her older daughter. Assessing her goals in parenthood, she gave up her dangerously overtaxing job, secured medical help for herself, and decided to devote her efforts to caring for her children, even though it meant accepting public assistance and the authority and limitations that go with it.

A followup visit 6 years later revealed that though Mrs. Ford had been hospitalized twice for a serious heart and kidney condition, Jane's seizures were still controlled. All three children were doing well. Mrs. Ford was relatively healthy and proud of her own and her family's progress.

Parents with social signs overweighted in the negative direction are those in our Group III classification—those whose children are in acute danger as long as they are in the home. The cases are grim. For example:

Jack Burt, 3 years old, dead on arrival, with continuous welts around both arms, across his back, a large swelling on his head, old burn scars from chest to lower abdomen. As his stepfather carried him in, a nurses' aide heard the man say, "I don't want any more of this; I won't take any more of this. No more." Depositing the boy's body on an examining table, he walked across the room, saying in casual social tones to the aide, "Don't I know you from somewhere? I'm sure I've met you somewhere before."

The physician's question brought, "I just hit him like I always do when he pees the bed. This time he went and fell on his head."

Review of the hospital records showed that 11 months before, Jack's sister, Rita, age 3 months, had been admitted for a head injury. The history noted, "Infant recently fell out of bed," and "An accidental 'clip' on the chin." These pieces of information had not been recognized in their true meanings.

Although Rita was already damaged, recognition of danger signals and request for careful social assessment and quick, joint medical-social action might have prevented further damage, and might have prevented Jack's torture and subsequent death. After Jack's death, Rita was placed in a foster home by a protective agency. She is now spastic, is apparently retarded, and needs expensive, protracted care.

Though both Mrs. Burt and her mother knew Jack was being "punished" by being placed on a hot gas burner, neither woman had asked for protective placement. Legal charges against the father came with Jack's death.

In another family, protection from permanent physical damage came in time:

Mary O'Toole, 3 years, 8 months, who had not previously been our patient, was presented in our receiving ward by both parents in late evening for a broken leg, multiple body bruises, a pulled-off fingernail, a large swelling on her forehead, all said by her parents to have been caused by clumsy Mary, whose behavior could not be controlled, who got struck by a car, who got her fingers stuck in a curtain rod. This time, according to the parents, she had fallen downstairs.

The O'Tooles asked that we find why Mary bruised so easily, what made her clumsy, and why she was so wild and careless. They showed no appropriate concern about her broken leg, her injuries, or her prognoses.

Behind their bringing the child to the hospital lay an anonymous report to the department of health that they had neglected Mary's twin siblings, aged 2½ months. The community nurse had called on the family and found that the twins were poorly cared for, as were their two other siblings, aged 4 years and 1 year. A friend of Mrs. O'Toole's was in the house at the time and drew the nurse's attention to Mary, who had been sitting quietly in the background, by saying, "Let's tell the nurse; we can trust her."

Both women said Mary had fallen that morning. The nurse advised emergency care since Mary's leg looked bad. Mrs. O'Toole said she would wait until her husband came home from work. The parents brought Mary to the hospital at 8:30 p.m. Her leg had been broken and untreated for at least 10 hours.

On the ward, Mary was quiet but continuously watchful. She ate ravenously, two and three of everything. Both parents evaded all responsibility for Mary's condition and seldom came to see her.

Mary said she had been pushed down the stairs. The O'Tooles are the only parents in our records who have been overheard telling a child not to talk, and Mary is the only child we know who "talked."

Despite this data, it was impossible to convince the protective agency that Mary needed protective care direct from hospital. Later, the protective agency moved all five O'Toole children into protective care.

Children's Reactions

The neglected, battered children brought to a hospital are often too young to tell how they were injured. If old enough, they may be afraid or ashamed to tell. Usually older children have learned to cover up. The signs of their fear of their parents are subtle rather than overt and can easily be overlooked.

Behavioral signs of abuse among infants are even more subtle than among children old enough to speak. There are, however, some noticeable contrasts among the well-nurtured infants and the severely battered or neglected. For example: Nurtured, cared for infants old enough to recognize their parents cry and roll toward them or reach for them. Neglected and battered infants shut their eyes, turn their heads or bodies away, and cry irritably. The more severe the neglect and battering, the more withdrawn or irritable the infant.

Some typical forms of behavior of well-nurtured children in a hospital:

1. Cling to parents when they are brought in.
2. Turn to their parents for assurance.
3. Turn to their parents for comfort during and after examination and treatment.
4. Constantly show by words and action that they want their parents and want to go home.
5. Are reassured by their parents' visits.

Children in this group do not have to have the total situation under inspection at all times for safety's sake. They find safety in their parents.

Some typical forms of behavior of neglected and battered children in a hospital:

1. Cry hopelessly under treatment and examination.
2. Cry very little in general.
3. Do not look to parents for assurance.
4. Show no real expectation of being comforted.
5. Are wary of physical contact initiated by parents or anyone else.
6. Are apprehensive when other children cry and watch them with curiosity.
7. Become apprehensive when adults approach some other crying child.
8. Seem less afraid than other children when admitted to the wards and settle in quickly.
9. Seem to seek safety in sizing up the situation rather than in their parents.
10. Are constantly on the alert for danger.
11. Are constantly asking in words and through their actions what will happen next.
12. Are constantly in search of something: food, favors, things, services.
13. Ask, "When am I going home?" or announce, "I'm *not* going home," rather than crying "I want to go home."
14. Assume a flat "poker face" when discharge home is mentioned or taking place.

In general, cared for children turn to their parents for safety in life. Neglected and battered children endure life as if they are alone in a dangerous world with no real hope of safety.

Some Implications

Because of the repugnance of the idea that parents could be cruel to their own children, parental neglect or abuse often goes unrecognized even after the children's conditions have become serious enough to require hospitalization. The social signs are therefore important aids to diagnosis for preventing further serious damage in children who have already been damaged by their own parents. We think however, that these signs can also be recognized in earlier stages in other settings, in some instances early enough to prevent the extreme deterioration in parent-child relationships that is behind the abusive behavior, or at least in getting services to the child and family before the deteriorated relationship has resulted in serious damage to the child. The signs can be observed by visiting nurses, child welfare workers, doctors and nurses in well-baby clinics, the staff of day-care centers, and others who have normal access to families and children and can set in motion the community services to bring protection to the child who needs it.

But community services must exist and work in a coordinated manner. For example, in extreme cases shelter care is necessary during periods of investigation and decision reaching. It is not safe for a child to remain in a neglecting-battering home during extended periods of investigation, pending court hearings. Neither should the child remain in a hospital ward used for acutely ill children when his physical condition no longer requires it.

Clear lines of accountability and coordination are necessary among the agencies involved. Laws requiring hospitals to report cases to the court should also require notification of child welfare services from the time reportage is thought necessary; otherwise fragmentation of knowledge and effort further endangers children.[8, 9] Public agencies are in a strategic leadership position for coordinating services and knowledge.

The maturational crisis following childbirth in which the social role of nurturing parenthood is assumed has proved to be a prime intervention period for preventing acute and chronic neglect.[3] Evidence from the fields of social work, pediatrics, psychology, child psychiatry, and animal experimentation points to the first few months of life as the period when neglect disrupts the integrative capacity of infant perceptual systems.[6, 10] In this same period, families integrate or disintegrate as parents master or fail to master their parental role tasks.

Old and orthodox methods of providing protective service are not enough. Creative new uses and new combinations of old services are necessary [1, 2, 11] as well as willingness to communicate and to experience the unpleasant truths in the neglected, battered-child syndrome. The apparent high incidence of infant, young child neglect and battering suggests need to extend the postnatal period of social public health supervision through the period of greatest infant vulnerability and across social class lines for families showing serious disturbance and difficulty in mastering tasks of parenthood.

Collaborative programs under public health and public child welfare aegis, using current services in new combinations, are in a strategic position for the earliest recognition of neglecting, battering families and for providing immediate and continuing protective services.

Preventing neglect and battering depends in the long run on preventing transmission of the kind of social deprivation which takes children's lives, damages their physical health, and retards their minds [12] and which contributes through those who survive to a rising population of next generation parents who will not be able to nurture children.

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[1] Morris, Marian G.; Gould, Robert W.: Role reversal: A concept in dealing with the neglected battered-child syndrome. *In* The neglected battered-child syndrome; role reversal in parents. Child Welfare League of America, New York. 1963.

[2] Ackerman, Nathan W.: Preventive implications of family research. *In* Prevention of mental disorders in children. (Gerald Caplan, ed.). Basic Books, New York. 1961.

[3] Barbero, Giulio J.; Morris, Marian G.; Reford, Margaret T.: Malidentification of mother-baby-father relationships expressed in infant failure to thrive. *In* the neglected battered-child syndrome: role reversal in parents. Child Welfare League of America, New York. 1963.

[4] Elmer, Elizabeth: Identification of abused children. *Children,* September–October 1963.

[5] Griffin, M. E.; Johnson, A. M.; Litin, E. M.: The transmission of supergo defects in the family. *In* A modern introduction to the family (N. W. Bell and E. W. Vogel, eds.). Free Press of Glencoe, Glencoe, Ill. 1960

[6] Prugh, D. G.; Harlow, R. G.: Masked deprivation in infants and young children. *In* Deprivation of maternal care—a reassessment of its effects. (WHO Public Health Paper No. 14). Columbia University Press, New York. 1962.

[7] Patton, R. G.; Gardner, L. I.: Growth failure in maternal deprivation. Charles C Thomas, Springfield, Ill. 1963.

[8] U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: The abused child: principles and suggested language for legislation on reporting of the physically abused child. 1963.

[9] American Humane Association: Position statement on proposals for mandatory reporting of suspected inflicted injuries on children. Denver, Colo. October 1962.

[10] Philbrick, E. B.: Treating parental pathology through child protective services. Children's Division, American Humane Association, Denver, Colo. 1960.

[11] Riese, H.: Heal the hurt child. University of Chicago Press, Chicago, Ill. 1962.

[12] Coleman, R. W.; Provence, S.: Environmental retardation (hospitalism) in infants living in families. *Pediatrics,* February 1957.

This is where social welfare had its start—among the lowliest of our communities. Any social agency, whether it is the nutrition association or a child's psychiatric clinic, that is not doing an important part of its work in the slums today has abandoned this heritage. And it has done so at the risk of fighting the little fires while the house is burning down.

Bob Modic, welfare reporter for the Cleveland Press, to the 1962 forum of the National Conference on Social Welfare.

Unmarried mothers prepare for their return to the community by . . .

ROLE PLAYING IN A MATERNITY HOME

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TODAY MANY NEW forms of therapy challenge the social work field and the traditional treatment methods. One is group therapy, which is becoming a more widely accepted and an increasingly practical form of therapeutic endeavor. The staff of the Florence Crittenton Maternity Home of Detroit, Mich., after reviewing the literature in the field, has been trying to evolve a technique of group therapy specific to the unmarried mother while continuing to use the established treatment of individual casework interviews. We have found the techniques of role playing and group discussion to be valuable additions in our treatment program.[1]

The Florence Crittenton Maternity Home of Detroit, a voluntary agency supported by fees from the clients and by the United Community Service of Metropolitan Detroit, provides a residence for 60 unmarried mothers, as well as an outpatient service. The entire program is treatment centered, with an interdisciplinary staff including persons from the fields of obstetrics, psychiatry, clinical psychology, social casework, social group work, occupational therapy, administration, nursing, and teaching. To these services were added the services of a group therapist in 1956. This was the psychologist, Rosemary Lippitt, who inaugurated and carried on the experiments to be described here. Since then three staff members trained in group therapy techniques as well as in social casework have continued them.

All of the unmarried mothers receive individual casework attention. The group living situation with its daily routines, the school, the medical care, the health programs, the group activities, psychological testing, and individual casework all are part of a total treatment program. The group therapy techniques were added on the theory that there are areas of universality in the problems presented by a maternity home's clientele which might be covered by a group method in a more meaningful and timesaving manner. The goal of the entire program is to give the unmarried mother some insight into the reason why she became pregnant, to help her develop greater ego strength, to provide as much support as possible in facing up to her problems, and to help with her social readaptation.

The maternity home provides an ideal setting for trying out role playing and other group therapy techniques. The environment is controlled, structured, and homogeneous. The girls' very presence indicates that they have common symptoms, common problems, and common needs specific to an unwed pregnancy.

There are, however, difficulties in setting up experimental situations for trying out role playing in a maternity home. One is the ever changing complexion of the population. In our home this population undergoes a complete turnover every 3 to 4 months. Another difficulty is presented by the wide age range. While 55 percent of our girls are under 17 years of age, the ages range from 11 to 38 years. Variations in intelligence have not been much of a problem since most of our girls have average intelligence. Differences in religious, racial, and socioeconomic background—which in our home covers the range found in the general population—do not present difficulties when the focus is on a problem common to all.

Early Methods

Because role playing as a technique for helping unmarried mothers with their specific problems is generally new in a maternity home, our techniques have been continually in a process of development with no distinct transition point between our early and newer methods. During the first year especially, various methods were used in an effort to find out what would be applicable to our particular clientele. Both in staff sessions and with the girls we attempted to define and discuss the technique of role playing, to take a census of the problems which might be approached through this method, to choose one problem for each group therapy session to work on, and to encourage the girls to participate in the activity. The simplest forms of role playing were introduced with film strips as starting points. Role playing for humor was used as one of the warming up techniques which have been advised "to induce spontaneous states." [2]

When a central problem was chosen by the group for the focus of the session, a situation was devised by the group director to be spontaneously dramatized by the girls. In the early stages the girls took the parts of other people in the structured situation, and the part of the unmarried mother was played by a staff member. Now the girls play their own roles.

Our goals from the beginning have been: (1) to help the unmarried mother gain some understanding of her own problem; (2) to help her work out a better method of approaching her family, employers, and school after her experience in the home; (3) to evolve some specific group therapy techniques for helping unmarried mothers deal with some problems common to all unmarried mothers. The techniques worked out during the first year have changed but little in the past 5 years.

Our original group was the entire population of the home. Attendance was compulsory. The sessions lasted an hour, with a series of 12 sessions extending over a 3-month period. Two or three weeks elapsed between each series. Thus we were able to begin with all the girls by introducing them to what role playing is, helping them to develop skills in the activity, and gradually shifting the focus to a concentration on how one would act or feel when faced with a specific problem. Then to the "classical techniques" of role playing [2] we added some group discussion, generally focused on the solutions suggested in the acting.

We also devised a technique of having the entire audience participate as one of the principal characters in the scene. In order to do this the group director usually asked all of the girls to think in terms of a character being portrayed in a dramatic scene. Then the director would interrupt the acting from time to time to ask a member of the group if she would do it the same way or another way, sometimes asking her to change places with the actor immediately in order to reveal her thinking. After several such changes there would be a general discussion of the best way to handle the problem being worked on.

We felt that these sessions must belong to the girls themselves if they were to gain maximum benefits from them. So the leader permitted full freedom of expression in acting and discussion.

Reaction sheets were also used. On these sheets the girls expressed their reactions to the session and suggested questions for future dramatizations, thus revealing the problems that were worrying them. We tabulated these problems regularly and found that the same ones were repeated frequently and that these fell into a rather orderly pattern, going from the more simple and obvious practical problems to the more complex and intensive emotional problems. The same types of questions were repeated by each succeeding group. Those most often asked were: "How to act in front of the baby's father?" "How to handle suspicions of your neighbors, relatives, and friends who do not know where you have been?" "How to prove to your parents that you can be trusted?" "How to explain to your new employer where you have been for the past few months?" "Is it better to go out with your old crowd or to develop a new one?" "If I have not told the father of the baby, how will I feel when I see him again?" "How will I feel when I see my friend with her new baby, when I have just given up mine for adoption?" "To go to the same school or a different one?"

No matter with how many groups this method was used nor how many sessions were held, the gamut of problems remained the same. Because of this we eventually came to the decision that a more planned procedure needed to be developed to cover more adequately the total area of the girls' concerns.

This led to the formulation of the series of 12 sessions. We begin by using pictures which can be cut from any magazine. In the first session each girl is given a picture and asked to think out in a few minutes what the person portrayed is feeling and doing. The girls then take turns coming to the front with their pictures, pretending to be the person on the picture and expressing that person's feelings. This procedure has the purpose of helping the girls learn how to express a feeling. After this we present simple situations for role playing and progress to more complex ones. As the group works together, members gain skill in spontaneity and a feeling of cohesiveness. Just as a caseworker carefully proceeds toward a goal in individual therapy, we work carefully toward our group therapy goals. If the girls achieve insights into the nature of some of their problems more rapidly in this way than in individual therapy, there is greater attainment of our overall goals for them in the short time they are with us.

When a girl acts out her thoughts and feelings about a situation, it becomes real to her, particularly if she is an adolescent. The part-taking gives her an opportunity for reality testing, which helps to strengthen her ego. Because the situations are the kind that all the girls are facing, she can mobilize and act out her hostilities, without fear of reprisals.

A tabulation of the checked responses and volunteered comments on 307 reaction sheets from the early days of the program indicates that on the whole the girls saw value in the experience. Among the checked responses were 154 that the meeting was "helpful;" 75, "very helpful;" 8, "extremely helpful;" 54, "a little help;" and 16, "no help at all." Typical of 102 of the volunteered comments was the statement: "I think it is helping me a lot to learn to work out my problems, instead of overlooking them." Among the other comments, 64 indicated that the respondents liked the discussion and acting out; 15, that they liked the friendly gathering with the other girls; 4, that they did not like anything about the meeting; and 4 suggested that the group be split into smaller groups. The rest contained no comments.

Present Methods

Over the years we have gained some knowledge, increased our skills, achieved new insights, recognized our mistakes, and so continually reevaluated and revised our methods and plans. Each role playing session is followed by a regularly scheduled staff conference, attended by the caseworkers, housemothers, psychologists, doctors, and a psychiatrist. At the meeting, the session's effects on individual girls and the group are discussed along with their implications for future sessions and the handling of individual girls.

We now work with the girls in three groups, instead of trying to deal with the total population as a group. When the therapy group consisted of the total population (usually from 40 to 55 girls) many problems arose. Sometimes there was difficulty in "warming up" or insufficient common interest. In other words the group director was dealing with a "crowd" and not a therapeutic community. Even our present groups may be too large. It would probably be better if we could have four instead of three. However, our three trained group therapists do not have sufficient time to take on a fourth group. The three groups consist of:

Group I: All girls who are new to the maternity home. The girls usually stay for three or four sessions in this group and then advance to one of the other two groups, according to age.

Group II: Girls under 18 who have had experience in Group I.

Group III: The more sophisticated girls who have had three or more sessions with either of the above two groups. This group is confined largely to girls over 18 so that problems of young adults can be discussed more freely.

This restructuring of the groups necessitated new subgoals for each group within the overall framework of the three major goals already mentioned. Our new goals now are:

Group I: Orientation or introduction to role playing to create ease and spontaneity. Insights into the girls' feelings about their problems may be gained.

Groups II and III: Strictly role playing focused on problems common to the group. Some insights into fears gained as well as social readaptation and social reorientation.

The sessions are still all unrehearsed and completely spontaneous. Prior to these sessions, however, plans regarding the focus of the session, the specific goal sought, and the degree of emotional intensity that can safely be allowed to develop are discussed by the staff in interdisciplinary conference. The procedures are similar to those which have been reported in use at the Pontiac State Hospital in Michigan where "plans are dependent upon the primary focus and the ego strength and personality of the patients concerned."[3] However, the questions raised are specifically pertinent to the needs of unmarried mothers.

Generally, problems likely to be encountered by all unmarried mothers are still the focus of the sessions, but the situation is designed to fit the need of one of the group members. Both real and make-believe occurrences are used as the framework for the acting. The make-believe situations help the girls develop a feeling of ease, temper their anxiety, and, because they are less threatening, hold their interest from one session to another. This is important where sessions are held only once a week. Make-believe scenes also bring about a greater degree of spontaneity and more ready participation, especially if the girl is fairly new to the group.

Usually girls are able to act out a situation in which they are intimately involved only after they have developed a feeling of security within the group. We have found, however, that generally actual situations can be approached more rapidly in the group setting than in the individual casework setting. As we work along with the group the members are able to devise their own situations. The group director, however, through questions and interruptions, directs the group's attention to what is happening in a way designed to have a therapeutic effect. She knows when and where to cut the scenes, not only to enhance the therapeutic effect but also to prevent damage from being done to the girl, or to her image in the group.

Whenever possible we have a staff observer or "co-therapist" attend the group sessions. This makes it possible for nonverbal communications to be observed more easily and for support to be provided a girl when none is forthcoming from the group. The co-therapist or staff observer, who may be the caseworker, the housemother, the doctor, the psychiatrist, or the psychologist, is also helpful in interpreting the session to the staff by giving an objective "third party" impression of how it seemed to go as well as by helping to evaluate the insights gained by the individual group members.

The Values

We continue to use "reaction sheets" and to tabulate the responses they contain. The problems expressed remain essentially the same. A tabulation of the check list responses on 305 reaction sheets from recent sessions gives the following evaluations: 32, "extremely helpful;" 68, "very helpful;" 109, "helpful;" 66, "a little helpful;" and 30, "no help."

Some rather typical comments from these reaction sheets were:

> "The small groups feel at ease—girls of the same age grow closer together and can express their feelings better."
>
> "We talk about things that sometimes we are scared to talk about."
>
> "We have been helped to solve problems we did not even realize we had."
>
> "This brings the situation into reality."

So we have come to feel that role playing is of value in our program. It helps the girls not only to understand better how others feel about their behavior, but also to know how to handle constructively their own feelings and behavior. It gives them an opportunity to experiment with different kinds of behavior in an effort to find an appropriate procedure to use after they return home. It also helps them to develop a more understanding attitude toward their parents, relatives, and friends. Moreover, through the common sharing of a problem in a group the girls learn that it is not theirs alone and through this they are able to develop greater self-assurance.

The more a girl participates in role playing, the more proficient she becomes in it and the more confidence she develops about her ability to handle herself naturally when she is actually faced with the problem she has feared. We believe that this technique is particularly valuable for helping girls who have difficulty in expressing their feelings, and also for helping those who learn best from seeing and being. Girls who already had enough self-assurance to handle difficult situations are encouraged to participate in the role playing in order to demonstrate their ability.

We believe that these role playing sessions enhance our program and leave the caseworker free to use her time to a better advantage. They facilitate the treatment of a larger number of patients because the participants in the discussions spread their newly achieved insight throughout the entire group. The sessions also help the girl who is not immediately amenable to individual therapy through offering her the support of the group.

Thus, we are convinced that role playing as described here can be used as an effective supplement to casework and other forms of group work in a maternity home. Through the combined therapeutic team a unity of purpose in the treatment of the girl as a whole person, not only for herself but in relation to her particular world, is achieved.

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[1] Steinmetz, Martha A.: An experiment in psychodrama at the Florence Crittenton Home. *Group Psychotherapy,* Vol. XI, No. 3, September 1958.

[2] Moreno, J. L.: Psychodrama. Vol. 1. Beacon House, New York. 1945.

[3] Parrish, Marguerite: A development of a psychodrama program. *Journal of Psychiatric Social Work,* April 1954.

A TRAINING CENTER FOR CHILD WELFARE STAFF

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EFFECTIVE WORK with families and children must be based upon a workable understanding of behavior, including principles underlying a sound approach to its modification, as well as some mastery of techniques and methods used in the helping process. Study after study suggests that many failures in child welfare work stem from staff insufficiently equipped to carry out the complex functions of child welfare service. Therefore, when the new Kentucky Department of Child Welfare was organized by legislative act in 1960, we on the administrative staff put our thoughts at once to the organization of a staff development program. What we envisioned and achieved, with considerable staff participation in planning, was a residential staff training center where groups of staff could stay together for periodic training sessions ranging in length from 2 days to 2 weeks. While the training program is designed primarily for professional and supervisory workers, with their constant need of refreshment in techniques and philosophy as experience ripens, other training sessions are provided for secretaries and clerical workers and for the child-care personnel of the Department's four institutions.

In addition to the usual public child welfare services, the Kentucky Department of Child Welfare administers an institution for dependent children and a reception center, a training school, and a camp for delinquent children and youth. Many courts call upon the Department for social studies of children in trouble and to supervise those placed on probation. The Department also makes placement plans for boys and girls leaving its institutions and provides aftercare supervision for them. It is also responsible for licensing private and local public child-caring and child-placing institutions and agencies, including day-care centers, and for supervising independent placements for adoption.

The entire program is State administered. All its field workers are employees of the State, even though they are stationed in some 60 local offices. Administratively, the State is divided into 12 districts, each headed up by a district supervisor, some of whom are aided by assistant district supervisors.

As in most public child welfare agencies, the Department's staff contains only a nucleus of persons with professional social work training. These, for the most part, occupy administrative and supervisory positions. The State merit system requires a college degree for employment as a child welfare worker, and most of the Department's workers have just that, most commonly having majored in the field of education. A large percentage of these workers are genuinely dedicated persons who are highly motivated to join in any program designed to better their performance.

The decision to establish a residential staff training center was based upon the conviction that through it we could offer a more intensive, and therefore more effective, training program than otherwise. Although some thought was given to establishing a center on the campus of a college or university, this was ruled out by the relatively high costs which might be involved in trying to provide housing and classroom space on an already overcrowded campus, as well as by our feeling that a "child welfare staff training center" might be somewhat lost within a larger educational setting.

Ultimately we established our center in one of the buildings of Kentucky Village, our largest State institution for delinquent youth. This location has a number of advantages. It offers an opportunity for a somewhat isolated retreat, since it is in a rural setting. Yet, it is only 6 miles from the city of Lexington with its restaurants, movies, and shops. Another advantage in using this location for the inservice training center is that this brings all our child welfare workers from throughout the State periodically to Kentucky Village, thus helping to draw institutional and field staff together.

A net saving of more than $30,000 was achieved through locating our center at the institution. During the first 2 years of its operation, more than 250 staff members came to the center for training. Collectively, they benefited from more than 3,000 days of training. Subsistence alone would have cost the Department perhaps $35,000 for the same quantity of training had staff been housed in some hotel or lodge.

Planning and Preparation

In planning the program, special attention was given to the physical accommodations provided at the center, as we wished them to reflect the importance of the center's role. While we realized that it might be possible to offer staff training "in a barn," we thought it could be done more effectively in an attractive, comfortable setting designed for educational purposes.

Careful consideration was given to the selection of furnishings and equipment. Ten rooms formerly used to house institutional staff were redecorated and refurnished. Seven of these became twin bedrooms, each with its own private bath. Two lounges were provided, one with television and the other with stereo. For the training sessions we chose a large room and equipped it with a conference table, comfortable chairs, a snack bar, a blackboard, slide and movie projectors, a tape recorder, and a small library. Arrangements were made for meals to be provided in the cafeteria which serves the Kentucky Village staff.

From the beginning, we have had some deep convictions about how to get the most out of an inservice training program. In addition to believing in the advantages of a residential-type training center, we were convinced that the more people contribute to a training program, the more they get out of it. Very early then, we began to engage staff intensively in planning the program. This involved, first, staff meetings in our central office followed by meetings in each district and institution. Every meeting focused upon the general questions of "What do I need to know more about?" and "How can I learn it?" Following the meetings, each staff member completed a simple form, indicating what he was interested in learning and giving any suggestions he had about ways of developing a sound and effective training program. These forms along with reports of all conferences and staff meetings were forwarded to the director of training.

Along with considerable enthusiasm, these reports revealed certain resistances to training: "Do we have to go?" "Wouldn't it be better for us to learn right here at home?" or "Wouldn't it be a good idea for our supervisor to go and bring back whatever would help us in our jobs?" However, the more frequent query was, "How soon can I come?"

We regard this staff preparation as an integral part of the program. By providing advance opportunities to ventilate thinking and feeling, it alleviated anxieties. By offering an opportunity to contribute to planning, it helped give the workers the feeling that this was truly their own training program. The selection of major subjects for the first training sessions was based upon staff suggestions. By thus beginning with what the workers wanted to learn, the administration in a sense told them "you are important."

On January 29, 1961, the training center was formally dedicated. High government officials and groups of children from the State institutions participated in the ceremony. This was followed by an open house attended by several hundred persons, interested citizens and Department staff members.

Because the effectiveness of our State child welfare program is directly influenced by the caliber of services provided by other child welfare agencies, particularly child-placing and child-caring institutions, we believe that the State should assume responsibility for providing training opportunities for the staffs of agencies too small to carry out an inservice training program of depth and breadth. Therefore, we have extended an open invitation from the onset to other agencies to enroll their staff members in our training program. To date six agencies have responded.

About 14 persons are included in each training group, or, as we call it, training team. Each team includes, from different areas of the State, persons having similar job responsibilities, work experience, and educational background.

In forming the teams to attend the center, care has been taken to insure that every procedure reflected respect, courtesy, and consideration for the trainees. Each trainee has been given at least a month's advance notice of his training session, a list of the team members, the agenda for the session, and directions for reaching the center. The role which the team members' thinking has played in shaping the agenda is emphasized at the time the employee is notified of his session. When the team members arrive at the center, a member of the central office staff is on hand to welcome and to help them get acquainted with one another and with their new surroundings.

Gripes and Satisfactions

The commissioner of the Department welcomes each new group at its initial session, thus emphasizing the importance of this program. He discusses "our child welfare program," pointing out certain strengths, weaknesses, and desirable goals. The effort is to encourage feelings of belonging and of sharing problems, responsibilities, and goals.

The staff of the Department has perhaps experienced more than a normal share of frustrations on the job. These can be traced to several organizational transfers of the child welfare program between various departments of State government, each transfer bringing changes in philosophy, policies, and procedures. Because of these experiences we regarded it as extremely important to provide the staff with opportunity to ventilate their feelings in a climate of acceptance. Therefore at first we scheduled a "gripes-satisfactions" discussion early in each training course. The director of training, who led these sessions, accepted all complaints without defensiveness, an important attitude for encouraging continued freedom of expression and securing a release which expedited learning. A shift in the middle of the session from "gripes" to "satisfactions" prevented a carry-over of feelings which might impede learning and set a positive tone for subsequent sessions.

In the sessions the leader made note of all "gripes" and "satisfactions" presented by each team, later assigning members of the group to put them in writing for referral to the commissioner for study and action. This activity gave the group a feeling of doing something concrete about their complaints and enabled the Department to use the "gripes" constructively. The commissioner responded to both "gripes" and "satisfactions" through a memorandum to the members of each group. This showed the staff that their complaints *had* been constructively channeled. It also informed them of changes planned as the result of their complaints or explained why suggested changes could not or would not be made.

Responses to the "gripes" session varied, yet some general pattern emerged. After a brief warmup in which the leader talked of the purpose and procedure of the session, the floor was open for "gripes." The initial take-off was invariably characterized by evident fears, uncertainties, and unsureness about what to say and whether to say it. Therefore, each group began with rather non-threatening matters: they were not receiving supplies they had requested; they did not have appropriate office furniture; the mail distribution from the central office was poor. As the members began to feel the general atmosphere of acceptance, the complaints gradually built up almost to a bursting point and were expressed in justifiable concerns about services to people.

Voicing and hearing deep-felt complaints brought the team members much release from their tensions. The descent from the peak of feelings reached was characterized by some quiet times interspersed with dribbles of inconsequential comments. Not until the last "dribble" was out did we turn the group's attention to satisfactions.

The discussion of satisfactions was marked by an almost over-exuberance in relating on-the-job satisfactions: The team members loved their jobs and would not change places with anyone; they thought the training program was wonderful; they really had an opportunity now to share experiences and learn together. When this was finished—and it was finished fairly quickly—there was some noticeable anxiety as the members suddenly realized that their "gripes" far outnumbered their satisfactions. At this point, the leader openly expressed support to alleviate tensions. From here on, observations by members of the group indicated steady movement toward group togetherness and in general a greater freedom to participate in the learning experience.

After two rounds of training for all staff, the "gripes-satisfactions" sessions were discontinued.

It was no longer essential to provide specific opportunities for staff to express negative feelings, as a tradition of acceptance and freedom had been established within the program. A problem solving session became the natural successor to the "gripes and satisfactions" sessions as staff were encouraged to assume more initiative in helping to improve the child welfare program.

Content of Sessions

Leadership for our training program has been drawn from several sources. A number of staff have served: the commissioner, director of training, supervisor of adoptions, consultant on group treatment, attorney, and juvenile court consultant. We have also brought in leaders from schools of social work, from other social agencies, and from industry.

The subjects studied and discussed in these sessions are those requested most frequently by staff. However, particular attention is given to the history and philosophy of social work in all first-round training sessions. This is done on the theory that the philosophy we hold should be "talked out" from time to time. There may be ready responses to what "I believe" but some deep thinking is demanded when it comes to "how I can carry out what I believe."

The question of what to teach loomed large in our planning of training for personnel without professional social work education. We wished to stay away from theoretical formulations which could not be used in practice—which indeed might destructively inhibit staff. An inservice training program cannot provide the knowledge and skill necessary for effective and safe use of many of the deeper and more complex theoretical concepts presented in graduate social work education.

We have focused upon the development of greater self-awareness. We have stimulated our workers to look at themselves; to recognize the emotional reactions, prejudices, preconceptions, and personal values which intrude upon our relations to others and to others' situations. We have presented some basic information on child growth and development with emphasis upon what is "normal" for children and youth. We have endeavored to create some appreciation of the complexity of human behavior and how it is influenced by many factors of which the subject may not be aware. We have tried to develop recognition of behavior, suggesting problems which need to be referred to some other source of service or at least require the worker to seek consultation from an expert.

We have stressed certain tried and true social work principles and techniques. We try to sensitize staff to search for the feelings which may lie behind words. We stress the importance of the client as a human being—each with his own feelings, hopes, fears, needs. We examine what goes into making the client feel accepted and wanted. We discuss what being a good listener means. We review the resources which might be found and used for and by our clients in various kinds of communities.

All these concepts, principles, and techniques are emphasized through repetition—through their presentation again and again in principle and precept with abundant use of case materials.

Timing and Devices

Our training sessions have been scheduled for 5½ hours each day, with morning and afternoon coffee breaks and a lunch hour. Occasional night assignments are given, and "open house" opportunities have been arranged for workers to visit the cottages and other parts of the institution. All child welfare workers report to the center for training at least twice each year.

After evaluating our experience with a 2-week session on our first round of training, we decided that 1 week was more desirable. The trainees were noticeably fatigued during the second week. Perhaps a session lasting longer than 2 weeks, say one of 5 or 6 weeks, would get the participants over the hump of the second-week fatigue and prove to be an effective training period. Shorter, more frequent training sessions seem more practical for us. Many of our staff have family responsibilities which make it difficult for them to be away from home for prolonged periods. Also, the shorter period means that caseloads are not left uncovered for so long a time.

We have experimented with a number of devices as learning aids. For example, we have invited a small group of carefully selected children from an institution to meet and talk with a training team about what they liked or did not like about social workers. The children were approached on the basis that they could help others by their participation. None of them came from the counties of the workers present. Subsequent discussion indicated that this meeting had considerable impact on the workers. They found it hard to believe that children who had been told repeatedly why they had been taken to an institution still did not understand why they had to live there. They were struck by the way the children counted off the days, weeks, and even months and years of their time in the institution. They talked at length about how the children continued to yearn for home and family. Two years later, workers still refer to the experience.

Another device was letter writing. In one session the workers were assigned to write a letter to an institutionalized child. Each worker dropped his letter in a "post office" box set up to receive them. Without identifying the writer, the leader read each letter aloud while the members of the group imagined themselves in the role of the child receiving it. This kind of role-playing evoked discussion of basic principles to follow in writing to children.

A third device was a special workshop, held at the center, on the group approach to treatment. Staff members who volunteered to attend were asked to come prepared to play the role of a juvenile delinquent with whom they had worked. The 18 persons from field and institutional staff who attended were divided into 2 groups. One group was moved back from the table initially and asked to observe. The other remained at the table and engaged in discussion. Later, the two groups switched roles. In both instances, the observers became so involved in following the discussion that they had difficulty in refraining from giving support and assistance to the "delinquents." These sessions elicited such comments from the staff as "It was the first time I really knew how a delinquent felt," and "I got so involved in playing the role that I really hated everybody."

Another training device used frequently is a simulated court hearing of an involuntary-termination-of-parental-rights proceeding. Frequently, our workers must testify in courts, a role which can seem threatening. Opportunity to participate in this simulated hearing has helped many of them feel secure in presenting materials to courts. Two of our staff attorneys act the roles of prosecuting and defense counsels; the case used is a real one; and the worker actually carrying the case is called upon to testify.

The Values

While it is impossible to pinpoint the exact effects of a training program of this kind, efforts have been made to evaluate its results. Each staff member has been asked to submit two evaluations following each round of training. The first is sent in within 1 week after the course; the second, 3 months later. The evaluations consist of a narrative statement in which the worker tells us what he thinks he learned, as well as what he thinks was not profitable. We also invite general comments and suggestions. Although these evaluations are not conclusive, they do suggest that our training program has contributed to staff development in a variety of ways.

Many staff members say they have returned to their jobs with fresh courage and renewed dedication. They report an increased sense of the importance of their job and themselves. They give considerable evidence of greater identification with the Department and increased feelings of "we-ness" among the staff. They report that great improvement has been achieved in the development of closer and more effective working relationships. Many also report that exposure to new insights and techniques has given them greater confidence in tackling difficult problems.

A number of workers have been stimulated by the training sessions to do further study on their own. Some have enrolled in college courses related to their field of work. Others have been led to work toward graduate social work study.

We recognize that staff would be more inclined to positive than to negative comments, even when these are submitted anonymously, and that we need more precise measurement of the effectiveness of the training program. We hope, at some point, to be able to provide the necessary research for this. We also see need to extend and strengthen the training program in a variety of ways.

The staff training program described here does not comprise the whole of the Department's activities in training and education, and will not even after it is strengthened and extended. Besides inservice training for its employed personnel, the Department also conducts a training program for volunteers. This recent development is paying big dividends. It offers summer employment to a number of undergraduate college students to stimulate or test their interest in a child welfare career. It provides a number of educational stipends for persons attending professional social work schools. It also provides field work placements for graduate social work students. All these activities, including the programs in the training center, are essential ingredients of our total staff development program.

THE PUBLIC HEALTH NURSE IN A PROGRAM FOR THE MENTALLY RETARDED

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THREE YEARS AGO a demonstration project was carried out in Long Beach, Calif., which has had far-reaching effects on the nursing services provided to families and children by the Long Beach City Department of Public Health. This was the provision of services for one year by the Traveling Diagnostic Clinic of the Children's Hospital of Los Angeles.

Operated by the hospital's child development clinic staff, the Traveling Diagnostic Clinic, a clinic for the mentally retarded, is a project supported with Federal funds from the Children's Bureau and sponsored by the California Department of Public Health, Bureau of Maternal and Child Health. Its purposes are to demonstrate the multidisciplinary approach to the problems of mental retardation, to interest and educate professional personnel in the field of mental retardation, and to stimulate communities to develop resources and facilities for the care of the retarded.[1] The clinic team consists of pediatrician, public health nurse, social worker, and psychologist.

The Long Beach City Department of Public Health serves a population of 357,000. The nursing division has a staff of 17 public health nurses, 3 nurses assigned to clinics, 1 licensed vocational nurse, 2 nursing supervisors, and a director. The major emphasis in the nursing service is on maternal and child health programs with approximately 70 percent of nursing time spent in these programs.

The department has long provided public health nursing service to families of mentally retarded children upon request of families, physicians, and social and health agencies. However, as time went on, it became evident that a more coordinated community approach was necessary if families were to receive the guidance and support they needed to help the children achieve their maximum potential. If hospitalization of the child was recommended, years of waiting for admission often ensued because of the overcrowded conditions in the State hospitals. Therefore, it seemed necessary to place greater emphasis on helping the family to maintain the retarded child in his home whenever feasible. As a spur to developing this kind of service, the health officer, after consultation with representatives of the State Department of Public Health and of local community groups, made the request for the Traveling Diagnostic Clinic.

Included in the groups consulted and kept informed of the plans were the Long Beach Children's Clinic, a nonprofit voluntary agency; the Family Counseling Service, also a voluntary agency; the

Exceptional Children's Foundation, an organization of parents of retarded children which maintains a school for the retarded; the public schools; a speech center; and the local pediatric society.

The Long Beach Children's Clinic provided space for the clinic and the first clinic session was held in May 1961.

Prior to the first session, a series of six orientation meetings, conducted by the staff of the clinic team, were held with the professional people of the community, including the health department staff. These meetings focused on the problems of mental retardation and their medical, social, psychological, and nursing aspects.

There was also preclinic planning within the nursing division of the health department. The nursing consultant from the traveling clinic team, the department's nursing director, and the nursing supervisors met to discuss the public health nursing aspects of the program and to arrange the necessary administrative details.

The Nurses' Functions

One nursing supervisor was assigned overall responsibility for the nursing division's participation in the clinic program. She attended all clinic staffings. This nurse assumed the team nurse's role after the demonstration project was completed and a community clinic established. Each nursing supervisor supervised her regularly assigned group of field nurses in regard to this program as well as the department's other programs.

Each public health field nurse was immediately involved in the evaluation of the clinic's patients from her district by contributing an assessment of each patient based on observations made in home visits. This assessment consisted of two parts:

1. The nurse compared the child's performance level with the performance level expected of normal children of his chronological age in order to gain an impression of his use of the intellect.

2. The nurse observed the problems of care and management the child was presenting to the family, forming an opinion of how well or how poorly the family was handling the child.

The second portion of the evaluation interrelated with the first, for the nurse often would be able to point out how parental management methods influenced the child's performance in either a positive or adverse way.

An important part of the nurse's first visit to the patient's home was her interpretation of the clinic service to the family. She also prepared the family for their visit to the clinic, explaining the various professional disciplines which would be represented there and the reasons why the parents would be expected to present the child before the group.

In order to demonstrate the public health nurse's role as a team member, the nursing consultant of the traveling clinic's team conducted each nurse's first evaluation visits with the public health field nurse acting as observer. After the visit, the team nurse and the field nurse discussed the content of the visit and then the team nurse prepared the written report, which she presented at the clinic with the field nurse observing. Thereafter, the field nurses conducted the visits to new patients on their own and presented their own reports at the clinic. The nursing supervisor assisted the field nurses in the preparation of their reports and was available to them for consultation. After the clinic evaluation of a child, the nurse who had made the initial evaluation continued to visit the family, basing her service to the family on the clinic's recommendations.

Over and over the field nurses were impressed by the way parental management influenced the child's performance.

For example:

> The team nurse and a field nurse visited Peter, aged 4, who had very little speech. During the visit, Peter displayed hyperactive and wildly undisciplined behavior. According to the mother's presentation of his development and level of self-care, the child seemed to perform at no higher than the 18-month level. He was not toilet trained, still took a bottle, and could barely feed himself dry foods with his fingers. Yet, during the course of the visit, the nurses watched the child take three parts of a vacuum cleaner, assemble them, plug in the cord, and turn on the switch—all evidence that the child had more intelligence than would be thought from his general performance. Investigation of the parents' methods of management revealed these to be so inappropriate and inconsistent that even a normal child under the same circumstances would have difficulty learning and adjusting.

In this case, the nurses who visited the home were able to list for the clinic many mismanagement factors relating to Peter's poor performance. Their findings were blended with those of the other team members to form a diagnosis of mental retardation less severe than first assumed, with an emotional overlay.

Staffing Sessions

Children under 6 years of age were admitted to the clinic's service on referral from a professional source. There was no financial screening during the demonstration period. The referrals were made to the health department's director of maternal and child health, who arranged for each child to have a nursing evaluation. Prior to the clinic's staffing session, the child was also seen at the clinic's Long Beach headquarters by the team's psychologist, and the parents by the team's social worker. Reports of these interviews, along with the nursing assessment, were made available to the clinic for the staffing conference.

The staffing sessions took place once a month and lasted for a full day. Four patients were scheduled for each session. The sessions were attended by a large number of people, including the family physician, representatives of the health department, the Long Beach Children's Clinic, the schools, the nearby State hospital for the retarded, and various social agencies and other professional persons acquainted with the families of the children to be presented. As many as 20 persons might participate in planning for one child.

The following case of a 4-year-old child referred for evaluation to the clinic by his pediatrician illustrates the usual clinical conference routine:

> Before the parents and child came in, the clinic's pediatrician opened the discussion by presenting the medical history, including the birth record and all prior medical and laboratory reports. Then the public health nurse, the social worker, and the psychologist reported on their observations.
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> The public health nurse said that the family lived in a substantial house, particularly suitable for caring for a retarded child because of an intercommunication system in the bedrooms and a fenced-in play yard. She assessed the child's general performance as at the 3-year level. She said she thought the family gave good care, but that the mother was so anxious that she was permitting the child to manipulate her. For example, the mother was feeding the child although he had the ability to feed himself. Noting other problems of discipline, the nurse expressed the view that the mother needed further help with management and the child group experience.
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> The social worker reported on the personality structure of the parents and the strengths and weaknesses of family functioning. She told of old unresolved problems which had been aroused at the time of the child's birth and were contributing to parental anxiety. Some initial counseling had been done. The psychologist, reporting on his findings, stressed the moderate degree of the child's retardation.
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> The parents and child then were asked to enter the room. The psychologist had the child demonstrate his ability to perform various developmental tests. The parents were further questioned about the child's history and drawn out about their view of his problem. As the doctor examined the child, he pointed out his findings for the benefit of the parents and the group. The family then withdrew.
>
> In the discussion which followed the pediatrician reviewed all the findings and indicated the prognosis from the medical point of view. The etiology of the problem was still unknown, but the degree of retardation present was moderate enough to allow for envisioning future placement of the child in a special class, perhaps eventually in a job. It was decided to recommend training class experience for the child, counseling for the parents from the local Family Service Agency, and continued public health nursing service. Representatives from the Family Service Agency and from the training class were present and helped make the recommendations. The family's physician agreed to continue to provide the child's health supervision.
>
> The parents returned to the room. The team's pediatrician gave a review of the medical problem and the present medical findings. The psychologist told of his findings and recommended the kind of training experience the child should have. The representative from the training class described for the parents the kind of program that could be offered the child. The social worker suggested further counseling to the parents and the representative from the Family Service Agency briefly described the service that the agency could offer. The nurse commented on what the child ought to be able to do for himself as indicated by his mental age and suggested a few ways in which self-feeding might be encouraged. Further questions by the parents were answered, and the group members commented positively on the parents' efforts on behalf of their child.
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> After the family left, the pediatrician led the group in further discussion of the case and its implications.

Forty-four children were seen during the demonstration period. Of these, 27, or 62 percent, were referred for public health nursing followup. Problems most commonly identified as needing nursing assistance were: feeding, training, discipline, and seizure control. Nursing also was recommended to offer emotional support and to help families utilize other community resources. Carrying out these recommendations involved home visits and conferences with other agency workers.

During the second half of the year of the demonstration (1961–62), a number of nursing staff meetings were held to discuss the progress of the patients served in the light of the findings and recommendations made at the clinic. The meetings were attended by the director of maternal and child health and the health department's social work consultant as well as by the department's nursing staff. The discussion revolved around the management problems of young retarded children. These meetings gave the nurses a chance to express their feelings and gain support from the other staff nurses in regard to cases in which progress of child and family was slow.

The demonstration convinced the Long Beach community that a multidisciplinary approach is necessary for helping families with retarded children. At the end of the demonstration period the visiting team withdrew and a community clinic for retarded children was established under the Long

Beach Children's Clinic. It continues to offer the same kind of service offered by the Traveling Diagnostic Clinic through the participation of pediatricians, social workers, and psychologist from the participating community. The health department provides the same nursing service as it did during the demonstration period, with the field nurses serving as team members. The patients are referred by a professional source, and a fee for the service has been established on a sliding scale.

Problems and Values

The introduction of any new program into a nursing service always poses administrative problems. This program has been no exception. There has been an increase in our nursing caseload of retarded children. We have found that more nursing time is needed for this service than for other maternal and child health programs as home visits are longer and recording is more detailed. More contact with other community agencies is necessary because the family problems are more severe. Most of the families referred for nursing followup need intensive and prolonged service, and the inability to provide the quantity of followup visits needed because of other work pressures has been frustrating to the nurses.

One of the biggest problems was finding enough clerical time to handle the correspondence and records, especially the time involved in obtaining medical histories and reports from previous medical sources. This was solved by obtaining part-time clerical help with funds allocated by the State from the Federal maternal and child health grant. Additional public health nursing staff was also obtained through this grant.

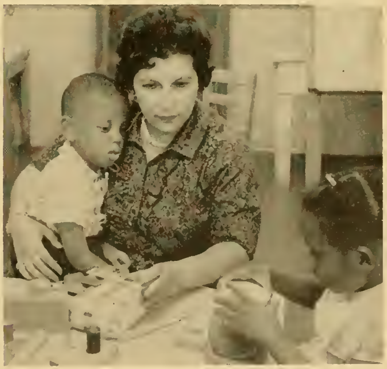
We also found that the nurses suffered an emotional impact in working with these families that they had to work through. This was similar to the emotional impact they experienced when we started visiting families of mentally ill patients. A considerable amount of supervisory time was devoted to listening and providing support to nurses as they vented their feelings about specific family situations. As one supervisor noted, "The nurses come back from clinic either in the clouds or in the depths, but in either case they have to talk about it."

Some of the nurses found it difficult to be a team member of the clinic—to make a nursing assessment of the child's development and performance and be prepared to defend it at the clinic staffing. This was partly due to their own anxieties about their knowledge of mental retardation and their inability to see themselves as contributing valuable information in the assessment of the child.

While the field nurses already knew much about normal growth and development and a great deal about sound child-rearing practices before the demonstration, they had considerable shyness in offering an assessment of the material they observed. They tended to equate assessment of the developmental level or performance level with diagnosis. Some of the nurses would have preferred to bring in the facts and let the pediatrician or psychologist draw the conclusions. When asked to place a value judgment on the child-care practices of the families seen in clinic and relate this to the patient's performance level, the nurses were even more hesitant. However, as the nurses observed in clinic, then later participated in staffings, their confidence grew as they saw their contributions welcomed by the other team members and put to use in the recommendations made.

In spite of all these problems, the benefits brought to our nursing service by this work with the mental retardation clinic have far exceeded the negative aspects. The greatest benefit has been that our total maternal and child health program has been enhanced by the nurses' increased knowledge and understanding of growth and development. The nurses' interest in parent-child relationships and their relationship to development has been stimulated considerably. As

Work with mentally retarded children in a clinic can enhance the public health nurse's understanding of human growth and development and help her to counsel parents realistically according to their child's performance and development levels.



a result, there is earlier casefinding of deviant behavior. There is evidence in the nurses' child health records of more attention being given to problems of discipline and management, and more realistic counseling of parents in relation to the child's developmental level.

There is still much to be learned about nursing service to families of the retarded—the kind of nursing care that is needed, the techniques of home training and counseling which are most effective, and the preparation and staffing necessary to provide it. There is a wealth of data available from nursing records but research personnel and funds are needed to make the necessary studies.

However, as a result of our experience, we are convinced that more emphasis on normal growth and development in basic nursing education is needed. We also believe that nurses generally need more preparation for helping families in crisis, not only in relation to mental retardation but in other nursing care problems—alcoholism, mental illness, suicidal tendencies. And we have learned that they need supervision in facing the emotional impact of these situations—to help them react with empathy rather than identification. Nurses especially need help in accepting the retardate's slow progress.

We believe that the nurse must have freedom to participate as a team member, not only in programs for the mentally retarded but also in other programs where the problems are equally as severe. In order to do this, she must be able to conceptualize and convey to other disciplines the nature of the nursing contribution.

Through this demonstration we have learned that field public health nurses have the potential to make good team members. With assistance they can learn to participate effectively in team evaluation. The nursing contribution can be defined and separated from the contribution of the other disciplines and plays an important part in the evaluation process.

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[1] Children's Hospital of Los Angeles, Child Development Clinic: Child development project annual report, 1961–62. Los Angeles, Calif.

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

A CHILD WAITS. 13 minutes; sound; black and white; purchase or rent.

In a series of still pictures, this film presents the story of placement by a social worker of an abused, neglected, 8-year-old Negro boy with foster parents. The narration is done by the foster father.

Audience: Potential foster parents and applicants, foster parent discussion groups, general public.

Produced by: Harvest Films for the Federation of Protestant Welfare Agencies.

Distributed by: Harvest Films, Inc., 98 Riverside Drive, New York 24.

YOUTH PHYSICAL FITNESS. 28 minutes; sound; color; loan.

Serving as a report to the Nation by the President's Council on Youth Fitness, this film stresses the need for vigorous activity programs in the Nation's schools. It shows how a city in Oklahoma developed a successful basic fitness program with a minimum of facilities. It also portrays a highly developed program of health and physical education in a Kansas community.

Audience: School officials, parents, community lay and professional groups.

Produced by: Robert Saudele Associates.

Distributed by: Equitable Life Assurance Society of the United States, 1285 Avenue of the Americas, New York 19.

THE SIXTH WHEEL. 20 minutes; sound; color; purchase.

A driver safety film portraying one day in the life of three drivers—a salesman, a housewife and mother, and a teenager. Depicts each driver's strengths' weaknesses, and near-misses during that day, pointing out the physical and emotional elements with which each has to cope.

Audience: Driver training classes, safety organizations, PTA's, community youth-service groups, and parent education groups.

Produced by: Sam Orleans Film Productions, Inc.

Distributed by: Sam Orleans Film Productions, Inc., 211 West Cumberland Avenue, Knoxville, Tenn.

THERAPEUTIC CAMPING. 28 minutes; sound; color; loan.

Portrays the multidisciplinary approach in a summer camp program designed to meet the needs of children with problems of learning or personal adjustment. The film's main character is Tom, an adolescent camper, who is helped to develop self-confidence, a sense of security, and meaningful interpersonal peer and adult relationships.

Audience: Parent education groups, community and church youth development groups, PTA's, child study groups, teachers, and undergraduate classes in psychology, psychiatry, sociology, and other related fields.

Produced by: Devereux Foundation.

Distributed by: Devereux Schools, in Devon, Pa.; Santa Barbara, Calif.; and Victoria, Tex.

BOOK NOTES

GROUP METHODS IN THE PUBLIC WELFARE PROGRAM. Norman Fenton and Kermit T. Wiltse. Pacific Books, Palo Alto, Calif. 1963. 274 pp. $3.50 paperback; $5.50 clothbound.

The variety of settings in which group methods can be used by local public welfare agencies is demonstrated in this collection of accounts by social workers of their experiences with this technique.

The book's spotlight is on pilot studies of the use of group methods in the San Francisco public welfare department and on demonstration-training programs of group counseling in 11 counties of California—called the County Project in the Welfare Program—which began in 1960.

The 30 chapters are arranged in 5 parts that touch successively on: the use of group methods in a public welfare program; group meetings largely informational in character; meeting informational needs of clients and approaching more intimate personal problems in a group setting; group counseling in the aid to needy children program; and the use of group counseling in other areas of the welfare program.

Expressed more than once in these chapters is the conviction that group counseling should not be used as a substitute for individual casework but rather as a complement and supplementary adjunct, nor should it be used as a covert means of manipulating the clients for hidden motives.

The director of the County Project in the Welfare Program and an associate professor of social welfare at the University of California are the editors.

THE DOCTOR AND HIS PATIENT. A sociological interpretation. Samuel W. Bloom. Russell Sage Foundation, New York. 1963. 270 pp. $4.50.

This sociological text designed for medical students and written by a sociologist on the faculty of the State University of New York College of Medicine, Downstate Medical Center, sets out some basic sociological principles rather than a survey of the field of sociology. The first of its 10 chapters brings out variations in attitudes toward health, illness, and medical care in the various subcultures and population subgroups.

Other chapters focus on the waxing position of medicine in the Western world; the interaction of patients and health personnel as seen by the sociologist; the modern hospital's metamorphosis into a "temple of medical science" generated by social, religious, and technological factors; bureaucratization; authority relationships; growth of the team approach to hospital medical care—with stress on role changes of the main participants; and the therapeutic community in the mental hospital. Throughout, the author attempts to portray the doctor-patient relationship as a "social system" rather than as an isolated dyad, explaining the physician's behavior against the background of the medical profession as a whole, and the patient's against the backdrop of family.

MENTALLY RETARDED CHILDREN AND THEIR EDUCATION. Elmer W. Weber. Charles C Thomas, Springfield, Ill. 1963. 338 pp. $10.75.

Within the 17 chapters of this textbook, the author, director of special education for the Evansville-Vanderburgh School Corporation of Evansville, Ind., first defines and discusses mental health, mental illness, and mental retardation and then traces trends and concepts in education of the retarded. He defines the broad goals of such education as similar to those of education generally—development to the highest degree possible of the individual's capacities to self-fulfillment and economic independence.

The author also outlines curriculum for educating the retarded, including methods—based on the retarded child's need for constant repetition and for activities that promote self-confidence and satisfaction—materials, equipment, and supplies. He especially underscores the value of music, recreation, language arts, practical and fine arts, social relationships, and social studies. The author also gives considerable attention to a consideration of the special characteristics of the mentally retarded child, parent counseling, and demonstrations of how the mentally retarded child learns more effectively in a special than in a regular class where his shortcomings are accented.

SEEDTIME OF REFORM: American social service and social action, 1918–1933. Clarke A. Chambers, University of Minnesota Press, Minneapolis. 1963. 326 pp. $6.50.

That so-called "wasteland of reform"—the years between the World War I armistice and the panic of 1929 when, in the words of John Haynes Holmes, people were "fat, corrupt, and contented"—has been probed by the author of this book and found to have borne the seeds of reforms to come. The author, a professor of history at the University of Minnesota, traces welfare research, agitation, and services with special accent on voluntary work during 1918–33.

The narrative is studded throughout with anecdotes and quotations from and about some of the personalities who dominated the social welfare movements of the times. It begins with accounts of some pre-war, wartime, and early postwar strides—particularly in labor legislation achieved by reform groups, such as the National Consumers' League, settlement and other social workers, "philanthropic women of substance and wealth," and professional and academic men who converged on city councils, lectured, wrote, and exhorted. Other chapters report on the "crusade for children," women's rights, social work in the 1920's, the beginning of the social insurance movement, demands for Federal action, the dawn of the New Deal. The main thread is the idea that much of the credit for New Deal social victories goes to the pioneers who kept alive the reform impulse in the preceding years.

HERE AND THERE

Federal Legislation

Last December, the Vocational Education Act of 1963—expanding and strengthening the Federal program of aid to State and local vocational education—was signed into law. The new legislation sets up the framework for an experimental program of residential vocational schools designed to help large urban areas with substantial numbers of unemployed high-school dropouts. Grants by the Commissioner of Education, authorized to begin in 1965, may go to educational agencies, organizations, or institutions for building and operating schools for youths between 15 and 21 years of age.

Another feature of the act authorizes payments for a student work-study program to benefit full-time high school students who need to earn in order to commence or complete their vocational education and who can keep good academic standing while employed. Work is limited to 15 hours a week when school is in session and must be for the local schools or a public agency.

Authorized for residential school and work-study programs are $30 million for fiscal year 1965, $50 million for fiscal year 1966, and $35 million for each of fiscal years 1967 and 1968.

The legislation broadens the definition of vocational education to embrace training in all gainful occupations, including training for business and office work, not previously covered in Federal programs. Funds earmarked for programs conducted under the Smith-Hughes or George-Barden Acts may be transferred to the new program. Also, appropriations for practical nursing and other health occupations are made permanent authorizations. Appropriations beginning with $60 million for fiscal year 1964 and increasing to $225 million for fiscal year 1967 and each fiscal year thereafter are authorized for State and local programs for students in or out of high school who are available for full-time study, the unemployed or underemployed, or those with socioeconomic or academic handicaps blocking success in regular vocational programs. These funds are also authorized for inservice teacher training, program evaluation, demonstration or experimental programs, and the development of materials for instruction.

Other provisions call for State matching, except for fiscal year 1964, and for periodic reviews by the Commissioner of Education of vocational education programs against a backdrop of manpower needs and job opportunities.

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In December 1963, amendments to the Manpower Development and Training Act of 1962 were passed by the 88th Congress, extending the act for an additional year and broadening its provisions. Appropriations of $407 million are authorized for fiscal year 1965, compared with $161 million allowed for fiscal year 1965 under the previous law. (See CHILDREN, July–August 1962, pp. 163–164.)

Outstanding features of the new legislation lower the age of youths eligible for training allowances from 19 to 17—but youths of the latter age must have been out of school a year; allow up to 25 percent of persons receiving training allowances to be youths under 22, compared with the previous limitation of 5 percent; add 20 weeks of basic education in reading and writing by illiterate trainees; allow increases in the weekly training allowance to $10 above the unemployment compensation payment, the previous limit; lower to 2 years, from 3, the prior work experience needed for training eligibility; and permit one member of a family whose head is unemployed to receive a training allowance, replacing the limitation of training eligibility to household heads.

Against Poverty

As part of a broad Federal program to fight economic distress in the Appalachian region, a million-dollar project designed to give financial aid and other welfare services to families of unemployed workers in seven Kentucky counties was approved in late January. The counties—selected on the basis of unemployment rates and other evidences of need—are Breathitt, Floyd, Knox, Leslie, Letcher, Perry, and Pike. The funds are provided through the Bureau of Family Services of the Welfare Administration. They are being used by the Kentucky Department of Economic Security during the first 6 months of 1964 to help families in which a parent is unable to find work and is ineligible for unemployment benefits. Before, the only public aid available to such families was surplus food.

To help these families become self-supporting, the project is enlisting the cooperation of schools, clinics, vocational training agencies, and other community resources. Public assistance to meet immediate needs ranges from $84 to $160, depending on the family's size.

The project is also expected to shed light on how long periods of poverty have affected these families—their living conditions, health, and the parents' ambitions for themselves and their children—as well as other information useful in constructing welfare programs.

Day Care

By the end of 1963, a total of 43 States had approved day-care plans for a variety of activities. All States except 6 now provide for the day care of children—32, for family day care; 18, for the operation of a day-care center; and 26, for the purchase of care in day-care centers.

One-fourth of the 43 States allow for the professional education of staff; and more than three-fourths, for institutes, conferences, and short-term courses. Cooperative projects with other agencies, public or voluntary, are planned by one-fourth of the States. All except 9 of the 43 provide for expenses of the State advisory committee.

Home and School

An educational experiment conducted by the Baltimore City Public Schools with a sample of disadvantaged 4-year-olds—to determine whether such a preschool program can block the rise of learning barriers that stem from home conditions during these early years—is now rounding out its second year of operation. The 3-year project was launched in October 1962 and began operations the next February with a budget of $330,000 from the Baltimore City Public Schools and the Ford Foundation.

Participating children were selected at random from applicants living in depressed areas of the city who met specific criteria showing family conditions unfavorable to proper child development and who met certain mental and physical health standards. Participation was restricted to 4-year-olds. Sixty children formed the initial sample, enrolling in centers in two of the city's public schools where they followed a nursery curriculum stressing development of cognitive skills and of wholesome self-concepts.

At the end of the school year, in June 1963, after 5 months of operation, the project showed statistically significant higher scoring for the group on the Columbia Mental Maturity Test and the Verbal Maturity Scale as compared with scores achieved at the project's start. Other progress was reported in auditory and visual discrimination, expressing new ideas and accepting new ones, talking to adults, and working with others. On entry into kindergarten, the participating children appeared to make easier adjustment than other pupils and to express themselves more readily.

During this school year which started in September 1963, a total of 140 children are enrolled in 4 centers—2 of which operate on a full-day, and 2 on a half-day schedule—and control groups have been set up in each center.

The project's long-range plans include longitudinal studies to gauge the effects of early school admission on the achievement and rate of progress of participating children when they continue in the regular school program.

Smoking

Over an early January weekend, the Surgeon General's Advisory Committee on Smoking and Health made public its judgment, in a 387-page report, that "cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate action." Created by the Surgeon General of the U.S. Public Health Service in the summer of 1962 in the wake of other investigations here and abroad centering on the smoking health problem, the panel of 11 experts reviewed and evaluated what it called "converging lines of evidence"—experimental, clinical, pathological, and demographic—to find that excessive cigarette smoking contributes substantially to mortality from lung cancer and from other specific diseases.

One principal finding was that:

- Among women who smoke cigarettes during pregnancy, there is a tendency to have babies of lower birth weight and there are a significantly greater number of premature deliveries.

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A national conference of high school youth to chart ways of informing young people about the dangers of smoking is to be held in Washington, D.C., from April 30 through May 2 under the auspices of the Children's Bureau. With the theme, "Youth, Smoking, and Health," the conference will be attended by two youth representatives from each State. Its program will be prepared by a committee of 10 young people who have shown leadership abilities in State Committees on Children and Youth or in participating in planning State conferences on smoking. This committee, with adult advisers, is meeting during the first 3 days of March to review a "gist," prepared for high school readers, of the report to the Surgeon General on smoking and health.

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During mid-fall of 1963, a yearlong drive to discourage cigarette smoking was begun in Baltimore's largest high school, Baltimore City College, with a student body of 3,500 boys. Cooperating in the campaign are the city's departments of education and health, Johns Hopkins University School of Hygiene and Public Health, and the American Cancer Society. The drive, which opened with the distribution of a questionnaire probing student's smoking habits and attitudes, features talks by physicians, posters, pamphlets, and films. In the spring another questionnaire is expected to be distributed to gauge the effectiveness of the effort.

For Youth

Spurred by the report of the Task Force on Manpower Conservation, estimating that a third of youths turning 18 years old would fail the preinduction examination for military service and recommending specific remedial actions, President Johnson laid the groundwork in January for a program to test draft eligibles earlier than is now the practice and to stimulate State and community agencies to offer counseling and remedial services where needed.

In harmony with recommendations of the task force, the President directed the United States Department of Defense and the Selective Service System to examine all new draft registrants (18-year-olds) who are out of school and otherwise available for service, instead of testing them at the current average age of 22 or 23 years. He also ordered the United States Departments of Labor and of Health, Education, and Welfare to establish a program for those failing the tests using all available vocational training, counseling, education, and related health services.

The task force, appointed in September 1963 by President Kennedy, estimated that about half of the 18-year-old rejectee group would be unfit medically and the other half would reflect inadequate education, cultural handicaps, and to some extent inherent lack of aptitude. Basing the report on its nationwide study of a sample of rejectees (see CHILDREN, January–February 1964, page 34), this body found that the majority of those rejected are victims of poverty and come from families that are abnormally large, broken by divorce or separation, or receiving public assistance; and of inadequate education—four out of five rejectees are school dropouts and 31 percent are unemployed, a rate higher than for all youths of comparable age. The study also showed that three out of four medical rejectees have treatable ailments and that the overwhelming majority of the group failing the mental test want combined job training and education. The task force recommended that the Nation's draft mechanism be used by current rehabilitative programs and that experiments be made with new and coordinated approaches, both toward reducing future rejections and toward services for those now disqualified.

Under the new program, which takes effect July 1, youths will be examined as soon as possible after registering for the draft. If they are rejected for medical reasons, they will be told why and their cases officially but confidentially referred to personal physicians or public health authorities on a voluntary basis, and followed up. Those rejected because of low mental achievement will be asked to report to new "manpower conservation units" in regional U.S. Employment Offices that will plan their education and training.

About 500,000 to 600,000 potential draftees are expected to be tested under this program within the next fiscal year. The Department of Health, Education, and Welfare is planning to expand its pilot program for medical rejectees, now in New York City and Philadelphia (see CHILDREN, January–February 1962, page 35), in order to demonstrate services at additional Armed Forces Examining Stations; and to set up more pilot projects for nonmedical rejectees in strategic locations. The Interdepartmental Committee on Children and Youth has dissolved its subcommittee that was appointed in 1961 to probe the effects of the peacetime draft on youth and the Nation, and expects to form another subcommittee focused on the adolescent girl.

Child Welfare Grants

Fourteen grants totaling $485,663 were awarded last December under the Child Welfare Research and Demonstration Grants program, which is administered by the Children's Bureau.

Grants to support new projects went to the Friendly House of Portland, Oreg. ($14,605), to demonstrate how professional social work can assist working parents in finding suitable private families to care for their children; the Florence Crittenden Association of America, Chicago, the National Conference of Catholic Charities, Washington, D.C., and the Salvation Army, New York ($29,527), to develop a system of reporting the characteristics of unwed mothers; Fisk University, Nashville, Tenn. ($45,644), to study the ability, achievement, and adjustment of Negro grade-school children in relation to family structure and social status; the University of Chicago ($24,526), to probe legal and social work practice in the termination of parental rights; the Child Welfare League of America, New York City ($16,020), to evaluate the outcome of adoptions of American Indian children by Caucasian families; the Family and Child Services, Washington, D.C. ($52,198), to study the personality development of adopted children during their middle childhood and early adolescence; and the National Association of Social Workers, New York City ($11,733), to study research approaches to the problem of manpower deficiencies in child welfare.

Still other grants for new projects were awarded to the Iowa Children's Society, Des Moines ($26,208), to demonstrate a new casework method of helping disturbed children in foster care; and the Kentucky Department of Child Welfare ($80,357), to demonstrate treatment and prevention of mental retardation stemming from social and cultural deprivation, through foster home care.

The remaining grants were awarded to continue ongoing projects of: the Community Council of Greater New York, to study what happens to families in the year before initial foster care placement of their children ($21,709); the Association for Retarded Infants Service and the Association for Homemaker's Service, New York City, to evaluate the particular benefits of homemaker service to a family with a mentally retarded infant or preschooler ($61,773); the Child Welfare League of America, New York City, to study the criteria for evaluating potential adoptive couples used by adoption workers ($14,700); Brandeis University, Waltham, Mass., to develop a cost analysis system for day-care centers ($33,128); and the Associated YM–YWHAs of Greater New York, to study problems confronted on integrating physically handicapped children with those not handicapped, in recreation groups ($53,535).

School Dropouts

About 51 percent of the 59,301 high school dropouts and potential dropouts reached in last summer's nationwide back to school campaign returned to school in November, according to U.S. Commissioner of Education Francis Keppel in a report on the 1963 campaign given to the President this winter. (See CHILDREN, November–December 1963, page 240.) The report announced that:

- The $250,000 in funds allocated for the campaign by President Kennedy was distributed in amounts ranging from $300 to $30,000 to 63 communities in 23 States and the District of Columbia.
- Cooperating in the campaign was the whole spectrum of community segments: State and local agencies, the press, radio and television, religious organizations, business, labor, civic groups, and the general public.
- As a result of the back to school drive, school systems are planning curriculum changes and special programs tailored to dropouts' needs among other efforts directed toward these youths.

Also, in the fall, public welfare agencies in 33 States and the District of Columbia began to prepare special drives to keep needy youths in school.

. . .

A work scholarship project to help prevent school dropouts by high school youths whose families receive aid to families with dependent children was initiated early this year by the District of Columbia Department of Public Welfare. The enterprise is supported by a grant of $101,179 from the Federal Welfare Administration, under authorization of a 1962 amendment to the Social Security Act allowing support of demonstration projects to strengthen public assistance programs.

The project, which will continue at least a year, is expected to award about 500 scholarships to students selected by school faculty, counselors, and administrators for performing such jobs as helping in the school office, library, bank, cafeteria, and on the school grounds.

Payments of $1.25 per hour for not more than 5 hours of work a week are excluded from those earnings that, according to Federal welfare regulations, have to be considered in setting a family's assistance.

The funds are issued through the District's Board of Education to avoid singling out children of dependent families from others in the schools' broad antidropout campaign.

Other Paths to Child Care

Gathering to hear about child-rearing programs in other lands and cultures, 43 specialists in child development and welfare—the majority from public or national voluntary agencies and organizations—attended the January 24 symposium on child welfare in Washington, D.C. The meeting, convened jointly by the International Union for Child Welfare and the U.S. Children's Bureau, was opened by Katherine B. Oettinger, chief of the Children's Bureau, who acted as co-chairman with Leonard W. Mayo, president of the International Union for Child Welfare—a federation of national and international organizations. Mrs. Oettinger observed that the experiences of all countries may illuminate new pathways to programs for children as well as for youth.

In one of the symposium's key presentations, Moshe Kol of Israel reported on that country's Youth Aliyah movement which he has directed for 10 years. He described the movement's origin as a mechanism for rescuing Jewish youth and children during the Second World War from countries under German control and for absorbing them into agricultural settlements, cooperatives of the kibbutz movement, and youth villages, then its gradual transition into a movement for child and youth care. Youth Aliyah, he estimated, has gathered and absorbed about 110,000 children and youth from over 80 countries—in Europe, Asia, Africa, and Latin America—and has seen them enter the ranks of teachers, educators, founders of new settlements, miners, kibbutz and settlement workers, white collar workers, artists, writers, soldiers, and even rabbis.

Another speaker told the symposium about institutional methods of upbringing in the Soviet Union: Urie Bronfenbrenner, social psychologist on the faculty of Cornell University, drew on observations and data collected during three recent visits to that country to describe a nationwide program introduced by Nikita Krushchev in 1956 to create a "new Soviet man." According to Professor Bronfenbrenner, the plan gradually shifts responsibility for child rearing from the family to the children's collectives, concentrating throughout on training for collective living and productive activity. From the nurseries, which children enter at 3 months of age, the children proceed to kindergarten and then to special boarding schools and "schools of the prolonged day," where they stay until they go home about 7 p.m. About 10 percent of the Soviet population of preschool and school-age children are reared thus, but, he concluded, the timetable calls for one-third of the children in the Soviet Union within these age groups to be absorbed in it by 1970, and all of such children to be included in it by 1980.

Noting that some of the many countries he has visited have excellent institutions for children, Martin Wolins, who is a faculty member of the School of Social Work of the University of California, discussing group care of children, warned against categorical disapproval of all institutions as unsuitable for child care. Some children are better off in an institution, in his opinion. "Better that we have good institutions than bad foster homes," he said.

At the symposium luncheon, Leonard W. Mayo reviewed the objectives of the International Union for Child Welfare. Among them: to help and protect all children of any race, nationality, or creed; to distribute information and to carry out research in child welfare problems; to stimulate child welfare work through conferences, working groups, and publications; and to link member organizations with the United Nations and its specialized agencies which have granted the International Union for Child Welfare consultative status.

The meeting closed with the afternoon session in which participants discussed the adaptability of some aspects of the group care programs of other countries for children in the disadvantaged sectors of this Nation's population. In this discussion it became apparent that some countries put a great deal of emphasis on what happens outside the child's home while in the United States emphasis is on what happens within the home.

READERS' EXCHANGE

PAVENSTEDT: *The nurse's role*

Some confusion may exist in the minds of readers about the role of nursing as discussed in the article, "A Child Guidance Service in a Municipal Hospital," by Dr. Eleanor Pavenstedt. [CHILDREN, November–December 1963.]

There are two graduate programs functioning at the Boston City Hospital, leading to a master of science degree in nursing from the Boston University School of Nursing. The nurses to whom Dr. Pavenstedt refers in the child guidance clinic and who are working with families are those preparing for nursing in child psychiatry. Those who are described as mental health nurses are the graduate students enrolled in the maternal and child health nursing program.

Although some of the children are referred directly from the pediatric ward to the child guidance clinic upon discharge, many others who are not need continuous care. For this reason, the graduate students specializing in maternity and pediatric nursing select families who are not currently receiving service from any other community service agency. This is a part of the graduate clinical experience which offers an opportunity to work with individual and groups of children in the ward setting.

Case material and the daily experiences of the students are discussed with the health team which is represented by a social caseworker, a child psychiatrist, a nursery school teacher who is also a parent, and with the maternity and pediatric nursing specialists of the faculty.

We find that most parents welcome the help of an interested nurse who cares about them, and who can appreciate their strengths as well as their weaknesses. The nurses of the pediatric unit of the Boston City Hospital felt that the families of some of their children needed more help than they could give in the hospital setting. We, therefore, incorporated this experience into our educational program so as to be able to look at the breadth and depth of clinical nursing as practiced in the maternity and pediatric units of hospitals.

We wonder what Dr. Pavenstedt may have meant when she states that consulting discussions with the nurse had best be kept at the level of management of the child. Her definition of the role of the nurse in pediatric nursing seems limited. Management, to us, encompasses not only knowledge related to family dynamics, but to all aspects of the growth of infants and children.

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A challenge

The memories evoked by Dr. Eleanor Pavenstedt's article of the dramatic quality of life within a large hospital are so colorful as to tempt one to overlook the value behind the descriptions. ["A Child Guidance Service in a Municipal Hospital," CHILDREN, November–December 1963.] To do so, however, would avoid two areas of consideration which should be emphasized.

One is the excellent description of the relationship between the disciplines that work closely with children. Dr. Pavenstedt's exposition of the dynamics of the day-to-day operation of so large an enterprise as the pediatric ward of a public city hospital carries with it a new picture of the problem of disciplines which work at different paces but which need to collaborate for effective treatment. Her article presents a real challenge to all psychiatrists, but particularly to those in such a setting, in its concern for the general physician who is at his wits' end with the emotional problems of a patient and needs assistance in dealing with them.

Inherent in the portrayal of this problem is the very great need to continue to study the process of how the two disciplines can work together to see where most effectively the psychiatrist can move in.

Dr. Pavenstedt deserves a special tribute for not describing the difficulties of such a situation *per se* but presenting them as opportunities. On first reading one is impressed by the poignant stories of the patients, but it quickly becomes obvious that at no point has the author suggested that the difficulties they present are insuperable. Rather she has used this highly challenging material to point up opportunities not only for treatment of patients but also for a new kind of operation of clinical activities. The entire presentation is an excellent antidote for anyone who feels he has therapeutic or process problems in a more organized and more cloistered environment.

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HILL: *Poor housekeeping in public housing*

Esther Hill in her article, "Helping Low-Income Parents: II. Through Homemaking Consultants" (CHILDREN, July–August 1963), described the first contact with a mother needing housekeeping help as a "friendly" visit which "would appear to many to be purely a social call." The hard-core poor housekeeper who resists help does not respond to this approach.

Such a group of housekeepers from Philadelphia's public low-rent housing were referred to Friends Neighborhood Guild, a local settlement house, for help. These families had been reported four times in 1 year by the Philadelphia Housing Authority building inspectors as poor housekeepers. Efforts of housing management aides and the social service department had not succeeded in helping them change their housekeeping practices. Because of the Guild's willingness to help these families, the housing managers agreed to delay lease cancellation 90 days.

In developing a special program to serve these families, funds were secured from the research grant program of the Social Security Administration, U.S. Department of Health, Education, and Welfare. An experimental research design was used with 20 poor housekeeping families serving as a control group and receiving no services, while another 20 families were offered the Guild program. The housing manager notified each family that they were being given 90 days to improve housekeeping or they would lose their leases. Noncontrol families were told they were being referred to Friends Neighborhood Guild for help. Each household was rated on its condition before and after the 90-day extension period.

The Guild service was geared to helping *all* members of the family. An initial home interview was held with each family to help them decide how to meet this crisis. The program offered homemaking help demonstrating proper cleaning techniques, use of proper equipment, development of daily routines, etc.; casework to help mothers use the services offered, to aid them in understanding the appropriate role of other family members in housekeeping, and referral to other agencies for help with problems which got in the way of housekeeping; weekly group discussions.

Services for other members of the family included weekly group discussions for boys and girls over 11 years to help them look at their respective roles in the home and see where they might take more responsibility. Fathers received individual counseling.

Some mothers readily agreed to use Guild help, while others were openly hostile, denying a housekeeping problem. One of the hardest responses to overcome was that of mothers who agreed to everything but never did anything.

When the 90-day extension ended and the family's housekeeping had been rated again, the Guild worker held a final interview with each family to discuss the rating and their plans for maintaining their housekeeping improvements. Of the group receiving Guild services, 10 families were rated satisfactorily by housing management and taken off the poor housekeeping list, 4 were rated as improving, 4 as not improving at all, and 2 had moved out. In the control group, two families were rated satisfactorily, nine families were rated as improving, six as not improving, and three had moved out. Major improvements were in housekeeping skills and ability to select priorities of housekeeping tasks. Results of the final ratings showed that *the experimental program was more effective than the control.*

Mildred W. Guinessy
Executive Director, Delaware Valley Settlement Alliance, Philadelphia, Pa.

Harold Lewis
Chairman, Research Department, University of Pennsylvania School of Social Work

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Page 73, Esther Bubley for the Children's Bureau.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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THE ABUSED CHILD: principles and suggested language for legislation on reporting of the physically abused child. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 13 pp. 10 cents.

The fourth of a series of legislative guides prepared by the Children's Bureau, this one proposes a State law for mandatory reporting to the police by physicians and institutions of physical abuse of children based on medical findings. (See CHILDREN, September–October 1963, page 202.)

SERVICES FOR CHILDREN: how Title V of the Social Security Act benefits children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Fact Sheet. 1963. 11 pp. Single copies available from the Bureau without charge.

Written in question and answer form, this pamphlet describes the nature and purposes of the three Federal-State programs provided for under Title V of the Social Security Act—maternal and child health services, services for crippled children, and child welfare services, including the provisions for child welfare research and demonstration grants.

JOB GUIDE FOR YOUNG WORKERS—1963–64 EDITION. U.S. Employment Service, and Bureau of Employment Security, Department of Labor. 1963. 77 pp. 45 cents.

This edition, prepared by the Office of Manpower Development and Utilization of the U.S. Employment Service, presents in chart form the types of occupations available to young people, their respective requirements and opportunities for advancement. It also provides advice to young job seekers on where and how to obtain information regarding local and out-of-area job prospects, required pre-training and on-the-job training, and State and Federal laws regulating the employment of young people.

SERVICES FOR FAMILIES LIVING IN PUBLIC HOUSING. Planning for health, education, and welfare services in the public housing community. The Committee on Use of Program Resources of the Joint Task Force on Health, Education, and Welfare Services and Housing. Department of Health, Education, and Welfare, and the Housing and Home Finance Agency. July 1963. 67 pp. Single copies free on request from the Bureau of Family Services, Department of Health, Education, and Welfare, Washington, D.C., 20201, or Management Division, Public Housing Administration, Washington, D.C., 20413.

This guide for managers of public housing projects outlines the kind of community resources that can be called upon for meeting the 12 most common social needs of families in public housing projects, and suggests methods for initiating action.

MENTAL RETARDATION. Activities of the U.S. Department of Health, Education, and Welfare. Department of Health, Education, and Welfare, Secretary's Committee on Mental Retardation. July 1963. 119 pp. 75 cents.

This report describes activities of current programs administered by agencies within the Department of Health, Education, and Welfare, which can serve as a foundation for implementing the major recommendations of the President's Panel on Mental Retardation. It also includes: a summary of the Panel's report; a portion of President Kennedy's special message on mental illness and mental retardation; and appendices containing, among other items, a selected bibliography of DHEW publications on mental retardation.

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Children's Intellectual Growth

Problems of Families with PKU

Differential Uses of Personnel

Suburbia as a Source of Foster Care

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HE EYES ARE OPENING to the wonders of the orld, not just the eyes of the baby rabbits but also hose of these children from an overcrowded inner-city eighborhood. The opportunity for this exciting experience is provided the children in an after-school rogram sponsored by the Play Schools Association, an organization that stresses the importance of play in the development of the school-age child. That play opportunities are also important as stimuli to the intellectual development of children in their preschool years is a major point made in the article which appears on pages 83–91 of this issue.

◀ *the authors*

With a Research Career Award from the National Institutes of Health, J. McVicker Hunt is focusing on the role of infantile experience in the development of intelligence and motivation. For 10 years he taught at Brown University, and for 10 more served as coordinator of training in clinical psychology at the University of Illinois, where he is a professor. For 5 years he served as director of the Institute of Welfare Research in the Community Service Society of New York.

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HOW CHILDREN DEVELOP INTELLECTUALLY

J. McVICKER HUNT

Professor of Psychology, University of Illinois

THE TASK of maximizing the intellectual potential of our children has acquired new urgency. Two of the top challenges of our day lie behind this urgency. First, the rapidly expanding role of technology, now taking the form of automation, decreases opportunity for persons of limited competence and skills while it increases opportunity for those competent in the use of written language, in mathematics, and in problem solving. Second, the challenge of eliminating racial discrimination requires not only equality of employment opportunity and social recognition for persons of equal competence, but also an equalization of the opportunity to develop that intellectual capacity and skill upon which competence is based.

During most of the past century anyone who entertained the idea of increasing the intellectual capacity of human beings was regarded as an unrealistic "do-gooder." Individuals, classes, and races were considered to be what they were because either God or their inheritance had made them that way; any attempt to raise the intelligence quotient (IQ) through experience met with contempt. Man's nature has not changed since World War II, but some of our conceptions of his nature have been changing rapidly. These changes make sensible the hope that, with improved understanding of early experience, we might counteract some of the worst effects of cultural deprivation and raise substantially the average level of intellectual capacity. This paper will attempt to show how and why these conceptions are changing, and will indicate the implications of these changes for experiments designed to provide corrective early experiences to children and to feed back information on ways of counteracting cultural deprivation.

Changing Beliefs

Fixed Intelligence. The notion of fixed intelligence has roots in Darwin's theory that evolution takes place through the variations in strains and species which enable them to survive to reproduce themselves. Finding in this the implicit assumption that adult characteristics are determined by heredity, Francis Galton, Darwin's younger cousin, reasoned that the improvement of man lies not in education, or euthenics, but in the selection of superior parents for the next generation—in other words, through eugenics. To this end, he founded an anthropometric laboratory to give simple sensory and motor tests (which failed, incidentally, to correlate with the qualities in which he was interested), established a

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eugenics society, and imparted his beliefs to his student, J. McKeen Cattell, who brought the tests to America.

About the same time G. Stanley Hall, an American who without knowing Darwin became an ardent evolutionist, imparted a similar faith in fixed intelligence to his students, among them such future leaders of the intelligence testing movement as H. H. Goddard, F. Kuhlmann, and Lewis Terman.[1] This faith included a belief in the constant intelligence quotient. The IQ, originally conceived by the German psychologist Wilhelm Stern, assumes that the rate of intellectual development can be specified by dividing the average age value of the tests passed (mental age) by the chronological age of the child.

The considerable debate over the constancy of the IQ might have been avoided if the work of the Danish geneticist Johannsen had been as well known in America as that of Gregor Mendel, who discovered the laws of hereditary transmission. Johannsen distinguished the genotype, which can be known only from the ancestry or progeny of an individual, from the phenotype, which can be directly observed and measured. Although the IQ was commonly treated as if it were a genotype (innate capacity), it is in fact a phenotype and, like all phenotypes (height, weight, language spoken), is a product of the genotype and the circumstances with which it has interacted.[1]

Johannsen's distinction makes possible the understanding of evidence dissonant with the notion of fixed intelligence. For instance, identical twins (with the same genotype) have been found to show differences in IQ of as much as 24 points when reared apart, and the degree of difference appears to be related to the degree of dissimilarity of the circumstances in which they were reared. Also, several investigators have reported finding substantial improvement in IQ after enrichment of experience, but their critics have attributed this to defects in experimental control.

An infant undertaking a test for brightness and coordination at the National Institutes of Health. Infant tests, according to current theory, have meaning in relation to a child's present development but little predictive value.

When results of various longitudinal studies available after World War II showed very low correlation between the preschool IQ and IQ at age 18, the critics responded by questioning the validity of the infant tests, even though Nancy Bayley [2] had actually found high correlations among tests given close together in time. Blaming the tests tended to hide the distinction that should have been made between cross-sectional validity and predictive validity: What a child does in the testing situation correlates substantially with what he will do in other situations, but attempting to predict what an IQ will be at age 18 from tests given at ages from birth to 4 years, before the schools have provided at least some standardization of circumstances, is like trying to predict how fast a feather will fall in a hurricane.

Predetermined Development. Three views of embryological and psychological development have held sway in the history of thought: preformationism, predeterminism, and interactionism.[1] As men gave up preformationism, the view that the organs and features of adulthood are preformed in the seed, they turned to predeterminism, the view that the organs and features of adulthood are hereditarily determined. G. Stanley Hall in emphasizing the concept of recapitulation—that the development of the individual summarizes the evolution of his species—drew the predeterministic moral that each behavior pattern manifest in a child is a natural stage with which no one should interfere. The lifework of Arnold Gesell exemplifies the resulting concern with the typical or average that has shaped child psychology during the past half century.

The theory of predetermined development got support from Coghill's finding that frogs and salamanders develop behaviorally as they mature anatomically, from head-end tailward and from inside out, and from Carmichael's finding that the swimming patterns of frogs and salamanders develop equally well whether inhibited by chloretone in the water or stimulated by vibration. Such findings appeared to generalize to children: The acquisition of such skills as walking, stair climbing, and buttoning cannot be speeded by training or exercise; Hopi children reared on cradleboards learn to walk at the same age as Hopi children reared with arms and legs free.[3]

Again, however, there was dissonant evidence. Although Cruze found that chicks kept in the dark decreased their pecking errors during the first 5 days after hatching—a result consonant with predeterminism—he also found that chicks kept in the dark for *20* days failed to improve their pecking. Moreover, studies of rats and dogs, based on the theorizing of Donald Hebb, suggest that the importance of infantile experience increases up the phylogenetic scale.[4]

Evidence that such findings may apply to human beings comes from studies by Goldfarb[5] which indicate that institutional rearing (where the environment is relatively restricted and unresponsive) results in lower intelligence, less ability to sustain a task, and more problems in interpersonal relations than foster-home rearing (where the environment provides more varied experiences and responsiveness). Wayne Dennis[6] has found that in a Teheran orphanage, where changes in ongoing stimulation were minimal, 60 percent of the 2-year-olds could not sit alone and 85 percent of the 4-year-olds could not walk alone. Such a finding dramatizes the great effect preverbal experience can have on even the rate of locomotor development. Presumably the effect on intellectual functions would be even greater.

Static Brain Function. In 1900, when C. Lloyd Morgan and E. L. Thorndike were attempting to explain learning in terms of stimulus-response bonds, they used the newly invented telephone as a mechanical model of the brain's operation. Thus they envisioned the brain as a static switchboard through which each stimulus could be connected with a variety of responses, which in turn could become the stimuli for still other responses.

Soon objective stimulus-response methodology produced evidence dissonant with this switchboard model theory, implying some kind of active processes going on between the ears. But it took the programing of electronic computers to clarify the general nature of the requirements for solving logical problems. Newell, Shaw, and Simon[7] describe three major components of these requirements: (1) memories, or information, coded and stored; (2) operations of a logical sort which can act upon the memories; and (3) hierarchically arranged programs of these operations for various purposes. Pribram[8] found a likely place for the brain's equivalents of such components within the intrinsic portions of the cerebrum which have no direct connections with either incoming fibers from the receptors of experience or outgoing fibers to the muscles and glands.

So, the electronic computer supplies a more nearly adequate mechanical model for brain functioning. Thus, experience may be regarded as programing the intrinsic portions of the cerebrum for learning and problem solving, and intellectual capacity at any given time may be conceived as a function of the nature and quality of this programing.[1, 9]

As Hebb[4] has pointed out, the portion of the brain directly connected with neither incoming nor outgoing fibers is very small in animals such as frogs and salamanders, whence came most of the evidence supporting the belief in predetermined development. The increasing proportion of the intrinsic portion of the brain in higher animals suggests an anatomic basis for the increasing role of infantile experience in development, as evidenced by the greater effect of rearing on problem solving ability in dogs than in rats.[9] Frogs and salamanders have a relatively higher capacity for regeneration than do mammals. This suggests that the chemical factors in the genes may have more complete control in these lower forms than they have further up the phylogenic scale.

Motivation by Need, Pain, and Sex. Our conception of motivation is also undergoing change. Although it has long been said that man does not live by bread alone, most behavioral scientists and physiologists have based their theorizing on the assumption that he does. Freud popularized the statement that "all behavior is motivated." He meant motivated by painful stimulation, homeostatic need, and sexual appetite or by acquired motives based on these; and this concept has generally been shared by physiologists and academic behavioral theorists.

Undoubtedly, painful stimulation and homeostatic need motivate all organisms, as sex motivates all mammalian organisms, but the assertion that all behavior is so motivated implies that organisms become quiescent in the absence of painful stimulation, homeostatic need, and sexual stimulation. Observation stubbornly indicates that they do not: Young animals and children are most likely to play in the absence of such motivation; young rats, cats, dogs, monkeys, chimpanzees, and humans work for nothing more substantial than the opportunity to perceive, manipulate, or explore novel circumstances.

This evidence implies that there must be some additional basis for motivation.

Reflex *vs.* Feedback. A change in our conception of the functional unit of the nervous system from the reflex arc to the feedback loop helps to suggest the nature of this other motivating mechanism. The conception of the reflex arc has its anatomical foundations in the Bell-Magendie law, based on Bell's discovery of separate ventral and dorsal roots of the spinal nerves and on Magendie's discovery that the dorsal roots have sensory or "input" functions while the ventral roots have motor or "output" functions. But the Bell-Magendie law was an overgeneralization, for motor fibers have been discovered within the presumably sensory dorsal roots, and sensory fibers have been discovered within the presumably motor ventral roots.

The most important argument against the reflex as the functional unit of the nervous system comes from the direct evidence of feedback in both sensory input and motor output. The neural activity that results when cats are exposed to a tone is markedly reduced when they are exposed to the sight of mice or the smell of fish, thus dramatizing feedback in sensory input. Feedback in motor output is dramatized by evidence that sensory input from the muscle spindles modulates the rate of motor firing to the muscles, thereby controlling the strength of contraction.[9]

Incongruity as Motivation. The feedback loop which constitutes a new conceptual unit of neural function supplies the basis for a new mechanism of motivation. Miller, Galanter, and Pribram [10] have called the feedback loop the Test-Operate-Test-Exit (TOTE) unit. Such a TOTE unit is, in principle, not unlike the room thermostat. The temperature at which the thermostat is set supplies a standard against which the temperature of the room is continually being tested. If the room temperature falls below this standard, the test yields an *incongruity* which starts the furnace to "operate," and it continues to operate until the room temperature has reached this standard. When the test yields *congruity*, the furnace stops operating and the system makes its exit. Similarly, a living organism is free to be otherwise motivated once such a system has made its exit.

Several classes of similarly operating standards can be identified for human beings. One might be described as the "comfort standard" in which incongruity is equivalent to pain. Another consists of those homeostatic standards for hunger (a low of glycogen in the bloodstream) and for thirst (a high level of hydrogen ion concentration within the blood and interstitial fluids). A third class, which stretches the concept of incongruity somewhat, is related to sex.

Other standards derive from the organism's informational interaction with the environment. Thus, a fourth class appears to consist of ongoing inputs, and, just as "one never hears the clock until it has stopped," any change in these ongoing inputs brings attention and excitement. Repeated encounters with such changes of input lead to expectations, which constitute a fifth class of standards. A sixth class consists of plans quite independent of painful stimulation, homeostatic need, or sex. Ideals constitute a seventh class.

There is evidence that incongruity with such standards will instigate action and produce excitement.[9] There is also evidence that an optimum of such incongruity exists. Too little produces boredom as it did among McGill students who would remain lying quietly in a room no more than 3 days, although they were paid $20 a day to do so.[9] Too much produces fearful emotional stress, as when a baby chimpanzee sees his keeper in a Halloween mask,[11] a human infant encounters strangers, or primitive men see an eclipse.

While this optimum of incongruity is still not well understood, it seems to involve the matching of incoming information with standards based on information already coded and stored within the cerebrum.[9] Probably only the individual himself can choose a source of input which provides him with an optimum of incongruity. His search for this optimum, however, explains that "growth motivation" which Froebel, the founder of the kindergarten movement, postulated and which John Dewey borrowed: and it may be the basic motivation underlying intellectual growth and the search for knowledge. Such motivation may be characterized as "intrinsic" because it inheres in the organism's informational interaction with the environment.

Emotional *vs.* Cognitive Experience. Another fundamental change is in the importance attributed to early—and especially very early—preverbal experience. Traditionally, very little significance had been attached to preverbal experience. When consciousness was believed to control conduct, infantile experience, typically not remembered, was regarded as having hardly any effect on adult behavior. Moreover, when development was conceived to be predetermined, infantile experience could have little importance. While Freud [12] believed that preverbal experiences were important, he argued that their importance derived from the instinctive impulses arising from painful stimulation, homeostatic need, and especially pleasure striving, which he saw as sexual in nature.

Freud's work spread the belief that early emotional experiences are important while early cognitive experiences are not. It now appears that the opposite may possibly be more nearly true. Objective studies furnish little evidence that the factors important according to Freud's theory of psychosexual development are significant.[13, 14] Even the belief that infants are sensitive organisms readily traumatized by painful stimulation or intense homeostatic need have been questioned as the result of studies involving the shocking of nursling rats.

Rats shocked before weaning are found to be less likely than rats left unmolested in the maternal nest to urinate and defecate in, or to hesitate entering, unfamiliar territory, and more likely to be active there. Moreover, as adults, rats shocked before weaning often require stronger shocks to instigate escape activity than do rats left unmolested; they also show less fixative effect from being shocked at the choice-point in a T-maze.[15] Evidence that children from low socioeconomic and educational classes, who have frequently known painful stimulation, are less likely to be fearful than middle class children, who have seldom known painful stimulation, suggests that the findings of these rat studies may apply to human beings.[16]

While such observations have contradicted the common conception of the importance of early emotional experience, the experiments stemming from Hebb's theorizing [4] have repeatedly demonstrated the importance of early perceptual and cognitive experience. At earlier phases of development, the variety of circumstances encountered appears to be most important; somewhat later, the responsiveness of the environment to the infant's activities appears to be central; and at a still later phase, the opportunity to understand the causation of mechanical and social relationships seems most significant.

In this connection, a study by Baldwin, Kalhorn, and Breese [17] found that the IQ's of 4- to 7-year-old children tend to increase with time if parental discipline consists of responsive and realistic explanations, but tend to fall if parental discipline consists of nonchalant unresponsiveness or of demands for obedience for its own sake, with painful stimulation as the alternative.

Motor Response and Receptor Input. One more important traditional belief about psychological development which may have to be changed concerns the relative importance of motor response and receptor input for the development of the autonomous central processes which mediate intellectual capacity. A century ago, the "apperceptive mass" conceived by Herbart, a German educational psychologist, was regarded as the product of previous perceptual input; and Froebel and Montessori both stressed sensory training. However, after World War I, the focus of laboratory learning-studies on response, coupled with the notion of brain function as a static switchboard, gradually shifted the emphasis from the perceptual input to the response output. It is hard to make the great importance attributed to the response side jibe with the following findings:

1. Hopi infants reared on cradleboards, where the movements of arms and legs are inhibited during waking hours, learn to walk at the same age as Hopi infants reared with arms and legs free.[3]

2. Eighty-five percent of the 4-year-olds in a Teheran orphanage, where variations in auditory and visual input were extremely limited, did not walk alone.[6]

Such observations and those of Piaget [18, 19] suggest that the repeated correction of expectations deriving from perceptual impressions and from cognitive accommodations gradually create the central processes mediating the logical operations of thought. Wohlwill [20] and Flavel [21] have assembled evidence which relates the inferential processes of thought to experience and have given this evidence some formal theoretical organization.

Counteracting Cultural Deprivation

The intellectual inferiority apparent among so many children of parents of low educational and socioeconomic status, regardless of race, is already evident by the time they begin kindergarten or first grade at age 5 or 6.[22] Such children are apt to have various linguistic liabilities: limited vocabularies, poor articulation, and syntactical deficiencies that are revealed in the tendency to rely on unusually short sentences with faulty grammar.[23] They also show perceptual deficiencies in the sense that they recognize fewer objects and situations than do most middle-class children. And perhaps more important, they usually have fewer interests than do the middle-class children who are the pace setters in the schools. Moreover, the objects recognized by and the interests of children typical of the lower class differ from those of children of the middle class. These deficiencies give such children the poor start which so commonly handicaps them ever after in scholastic competition.

So long as it was assumed that intelligence is fixed and development is predetermined, the intellectual inferiority of children from families of low educational and socioeconomic status had to be considered an unalterable consequence of their genes. With the changes in our conception of man's intellectual development, outlined in the foregoing pages, there emerges a hope of combating such inferiority by altering, for part of their waking hours, the conditions under which such children develop. The question is "how?"

Clues From Intrinsic Motivation. A tentative answer, worthy at least of investigative demonstration, is suggested by the existence of a change during the preschool years in the nature of what I have called "intrinsic motivation." An approximation of the character of this change has been supplied by the observations which Piaget made on the development of his three children.[18, 19, 24] At least three stages in the development of intrinsic motivation appear. These may be characteristic of an organism's progressive relationship with any new set of circumstances and seem to be stages in infant development only because the child is encountering so many new sets of circumstances during his first 2 or 3 years.

In the first stage the infant is essentially responsive. He is motivated, of course, by painful stimulation, homeostatic need, and, in Freud's sense, by sex. Russian investigators have shown that the orienting response is ready-made at birth in all mammals, including human beings.[25] Thus, any changes in the ongoing perceptual input will attract attention and excite the infant. During this phase each of the ready-made sensorimotor organizations—sucking, looking, listening, vocalizing, grasping, and wiggling—changes, by something like Pavlov's conditioning process, to become coordinated with the others. Thus, something heard becomes something to look at, something to look at becomes something to grasp, and something to grasp becomes something to suck. This phase ends with a "landmark of transition" in which the infant, having repeatedly encountered certain patterns of stimulus change, tries actively to retain or regain them.[24]

During the second stage the infant manifests interest in, and efforts to retain, something newly recognized as familiar—a repeatedly encountered pattern of change in perceptual input. The infant's intentional effort is familiar to anyone who has jounced a child on his knee and then stopped his jouncing only to find the child making a comparable motion, as if to invite the jouncing adult to continue. Regaining the newly recognized activity commonly brings forth such signs of delight as the smile and the laugh, and continued loss brings signs of distress. The effort to retain the newly recognized may well account for the long hours of hand watching and babbling commonly observed during the child's third, fourth, and fifth months. This second stage ends when, with these repeated encounters, the child becomes bored with the familiar and turns his interest to whatever is novel in familiar situations.[24]

The third stage begins with this interest in the novel within a familiar context, which typically becomes noticeable during the last few months of the first year of life. Piaget[18] describes its beginnings with the appearance of throwing, but it probably can be found earlier. While he throws the child intentionally shifts his attention from the act of throwing to the trajectory of the object that he has thrown.

Interest in the novel is also revealed in the infant's increasing development of new plans through an active, creative process of groping, characterized by C. Lloyd Morgan as "trial-and-error." It also shows in the child's increasing attempts to imitate new vocal patterns and gestures.[19, 24]

Interest in the new is the infant's basis for "growth motivation." It has also been found in animals, particularly in an experiment in which rats in a figure-eight maze regularly changed their preference to the more complex loop.

Thus Piaget's[18] aphorism, "the more a child has seen and heard, the more he wants to see and hear," may be explained. The more different visual and auditory changes the child encounters during the first stage, the more of these will he recognize with interest during the second stage. The more he recognizes during the second stage, the more of these will provide novel features to attract him during the third stage.

Effects of Social Environment. Such development prepares the child to go on developing. But continuing development appears to demand a relationship with adults who enable the infant to pursue his locomotor and manipulative intentions and who answer his endless questions of "what's that?", "is it a 'this' or a 'that'?", and "why is it a 'this' or a 'that'?". Without these supports during the second, third, and fourth years of life, a child cannot continue to profit no matter how favorable his circumstances during his first year.

Although we still know far too little about intellectual development to say anything with great confidence, it is unlikely that most infants in families of low socioeconomic status suffer great deprivation during their first year. Since one distinguishing feature of poverty is crowding, it is conceivable that an infant may actually encounter a wider variety of visual and auditory inputs in conditions of poverty than in most middle- or upper-class homes. This should facilitate the intellectual development of the infant during his first year.

During the second year, however, crowded living conditions would probably hamper development. As an infant begins to move under his own power, to manipulate things, and to throw things, he is likely to get in the way of adults who are apt already to be ill-tempered from their own discomforts and frustrations. Such situations are dramatized in Lewis's "The Children of Sanchez," an anthropological study of life in poverty.[26] In such an atmosphere, a child's opportunity to carry out the activities required for his locomotor and manipulative development must almost inevitably be sharply curbed.

Moreover, late in his second or early in his third year, after he has developed a number of pseudo-words and achieved the "learning set" that "things have names," the child in a crowded, poverty-stricken family probably meets another obstacle: His questions too seldom bring suitable answers, and too often bring punishment that inhibits further questioning. Moreover, the conditions that originally provided a rich variety of input for the very young infant now supply a paucity of suitable playthings and models for imitation.

The effects of a lower-class environment on a child's development may become even more serious during his fourth and fifth years. Furthermore, the longer these conditions continue, the more likely the effects are to be lasting. Evidence from animal studies supports this: Tadpoles immobilized with chloretone for 8 days are not greatly hampered in the development of their swimming patterns, but immobilization for 13 days leaves their swimming patterns permanently impaired; chicks kept in darkness for as many as 5 days show no apparent defects in their pecking responses, but keeping them in darkness for 8 or more days results in chicks which never learn to peck at all.[1]

Something new has attracted the attention of this child in a day-care center where a variety of toys and manipulatable objects stimulates the child's creative imagination.

Possible Counteracting Measures. Such observations suggest that if nursery schools or day-care centers were arranged for culturally deprived children from age 4—or preferably from age 3—until time for school at 5 or 6 some of the worst effects of their rearing might be substantially reduced.

Counteracting cultural deprivation at this stage of development might best be accomplished by giving the child the opportunity to encounter a wide variety of objects, pictures, and appropriate behavioral models, and by giving him social approval for appropriate behavior. The setting should encourage him to indulge his inclinations to scrutinize and manipulate the new objects as long as he is interested and should provide him with appropriate answers to his questions. Such varied experiences would foster the development of representative imagery which could then be the referents for spoken words and later for written language.

Children aged 3 and 4 should have the opportunity to hear people speak who provide syntactical models of standard grammar. The behavioral models would

A research-oriented nursery school in an underprivileged neighborhood of Pittsburgh provides this little girl with an opportunity to play house, and a pediatric psychiatrist a chance to observe aspects of children's behavior.

lead gradually to interest in pictures, written words, and books. The objects provided and appropriate answers to the "why" questions would lead to interest in understanding the workings of things and the consequences of social conduct. Thus, the child might gradually overcome most of the typical handicaps of his lower-class rearing by the time he enters grade school.

There is a danger, however, in attempting to prescribe a remedy for cultural deprivation at this stage of knowledge. Any specific prescription of objects, pictures, behavioral models, and forms of social reinforcement may fail to provide that attractive degree of incongruity with the impressions which the toddler of the lower class has already coded and stored in the course of his experience. Moreover, what seem to be appropriate behavioral models may merely produce conflict. Therefore, it may be wise to reexamine the educational contributions of Maria Montessori.[27, 28] These have been largely forgotten in America, perhaps because they were until recently too dissonant with the dominant notions of motivation and the importance attributed to motor responses in development.

Montessori's contributions are especially interesting, despite some of the rigid orthodoxy that has crept into present-day Montessori practice, because she based her teaching methods on children's spontaneous interest in learning, that is, on "intrinsic motivation." Moreover, she stressed the importance of teachers' observing children to discover what things would most interest them and most foster their growth. Further, she stressed the need to train the perceptual processes, or what we would today call the information processes. The coded information stored in culturally deprived children from lower-class backgrounds differs from that stored in children with middle-class backgrounds. This difference makes it dangerous for middle-class teachers to prescribe intuitively on the basis of their own experiences or of their experiences in teaching middle-class youngsters.

Montessori also broke the lockstep in the education of young children. She made no effort to keep them doing the same thing at the same time. Rather, each child was free to examine and work with whatever happened to interest him, for as long as he liked. It is commonly believed that the activity of preschoolers must be changed every 10 or 15 minutes or the children become bored. But Dorothy Canfield Fisher,[29] the novelist, who spent the winter of 1910–11 at Montessori's Casa de Bambini in Rome, observed that 3-year-olds there commonly remained engrossed in such mundane activities as buttoning and unbuttoning for 2 hours or more at a time. In such a setting the child has an opportunity to find those particular circumstances which match his own particular phase of development and which provide the proper degree of incongruity for intrinsic motivation. This may well have the corollary advantage of making learning fun and the school setting interesting and attractive.

Montessori also included children from 3 to 6 years old in the same group. In view of the changes that occur in intellectual development, this has the advantage of providing younger children with a variety of novel models for imitation while supplying older children with an opportunity to teach, an activity which provides many of its own rewards.

Conclusions. At this stage of history and knowledge, no one can blueprint a program of preschool enrichment that will with certainty be an effective antidote for the cultural deprivation of children. On the other hand, the revolutionary changes taking place in the traditional beliefs about the development of human capacity and motivation make it sensible to hope that a program of preschool enrichment may ultimately be made effective. The task calls for creative innovations and careful evaluative studies of their effectiveness.

Discoveries of effective innovations will contribute also to the general theory of intellectual development and become significant for the rearing and education of all children. Effective innovations will also help to minimize those racial differences in school achievement which derive from cultural deprivation and so help to remove one stubborn obstacle in the way of racial integration.

Although it is likely that no society has ever made the most of the intellectual potential of its members, the increasing role of technology in our culture demands that we do better than others ever have. To do so we must become more concerned with intellectual development during the preschool years and especially with the effects of cultural deprivation.

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[1] Hunt, J. McV.: Intelligence and experience. Ronald Press Co., New York. 1961.

[2] Bayley, Nancy: Mental growth in young children. *In* Thirty-ninth yearbook of the National Society for the Study of Education, part II. Public School Publishing Co., Bloomington, Ill. 1940.

[3] Dennis, W.; Dennis, Marsena G.: The effect of cradling practice upon the onset of walking in Hopi children. *Journal of Genetic Psychology*, vol. 56, 1940.

[4] Hebb, D. O.: The organization of behavior. John Wiley & Sons, New York. 1949.

[5] Goldfarb, W.: The effects of early institutional care on adolescent personality. *Journal of Experimental Education*, vol. 12, 1953.

[6] Dennis, W.: Causes of retardation among institutional children: Iran. *Journal of Genetic Psychology*, vol. 96, 1960.

[7] Newell A.; Shaw, J. C.; Simon, H. A.; Elements of a theory of human problem-solving. *Psychological Review*, vol. 65, 1958.

[8] Pribram, K. H.: A review of theory in physiological psychology. *Annual Review of Psychology*, vol. 11, 1960.

[9] Hunt, J. McV.: Motivation inherent in information processing and action. *In* Motivation and social interaction: cognitive determinants. (O. J. Harvey, ed.) Ronald Press Co., New York. 1963.

[10] Miller, G. A.; Galanter, E.; Pribram, K. H.: Plans and the structure of behavior. Henry Holt & Co., New York. 1960.

[11] Hebb, D. O.: On the nature of fear. *Psychological Review*, vol. 53, 1946.

[12] Freud, S.: Three contributions to the theory of sex. *In* The basic writings of Sigmund Freud. (A. A. Brill, ed.) Modern Library, New York. 1938.

[13] Hunt, J. McV.: Experimental psychoanalysis. *In* The encyclopedia of psychology. (P. L. Harriman, ed.) Philosophical Library, New York. 1946.

[14] Orlansky, H.: Infant care and personality. *Psychological Bulletin*, vol. 46, 1949.

[15] Salama, A. A.: Hunt, J. McV.: "Fixation" in the rat as a function of infantile shocking, handling, and gentling. *Journal of Genetic Psychology*, vol. 100, 1964.

[16] Holmes, F. B.: An experimental study of the fears of young children. *In* Children's fears. (A. T. Jersild; F. B. Holmes.) Child Development Monographs, No. 20., Teachers College, Columbia University, New York. 1935.

[17] Baldwin, A. L.; Kalhorn, J.; Breese, F. H.: Patterns of parent behavior. *Psychological Monographs*, vol. 58, 1945.

[18] Piaget, J.: The origins of intelligence in children (1936). (Translated by Margaret Cook) International Universities Press, New York. 1952.

[19] ———: Play, dreams, and imitation in childhood (1945). (Translation of *La formation du symbole chez l'enfant* by C. Gattegno and F. M. Hodgson.) W. W. Norton & Co., New York. 1951.

[20] Wohlwill, J. F.: Developmental studies of perception. *Psychological Bulletin*, vol. 57, 1960.

[21] Flavel, J. H.: The developmental psychology of Jean Piaget. D. Van Nostrand Co., New York. 1963.

[22] Kennedy, W. A., et al.: A normative sample of intelligence and achievement of Negro elementary school children in the Southeastern United States. *Monographs of the Society for Research in Child Development*, Serial No. 90, vol. 28, 1963.

[23] John, Vera P.: The intellectual development of slum children. *Merrill-Palmer Quarterly*, vol. 10, 1964.

[24] Hunt, J. McV.: Piaget's observations as a source of hypotheses concerning motivation. *Merrill-Palmer Quarterly*, vol. 9, 1963.

[25] Razran, G.: The observable unconscious and the inferable conscious in current Soviet psychophysiology: interoceptive conditioning, semantic conditioning, and the orienting reflex. *Psychological Review*, vol. 68, 1961.

[26] Lewis, O.: The children of Sanchez. Random House, New York. 1961.

[27] Montessori, Maria: The Montessori method (1907). Frederick A. Stokes, New York. 1912.

[28] Rambusch, Nancy McC.: Learning how to learn: an American approach to Montessori. Helicon Press, Baltimore, Md. 1962.

[29] Fisher, Dorothy Canfield: A Montessori mother. Henry Holt & Co., New York. 1912.

But whatever the cause, our joint Federal-local effort must pursue poverty, pursue it wherever it exists, in city slums and small towns, in sharecropper shacks or in migrant worker camps, on Indian reservations, among whites as well as Negroes, among the young as well as the aged, in the boomtown and in the depressed areas.

President Lyndon B. Johnson, in his state of the Union message to the 88th Congress, January 8, 1964.

PARENTS OF CHILDREN WITH PHENYLKETONURIA

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SINCE JANUARY 1961, a group of parents of children with phenylketonuria (PKU), an inborn error of metabolism, has been meeting under the guidance of the social worker of the Child Development Clinic at the Childrens Hospital of Los Angeles. The experience has added to our understanding of the problems families face in managing the complicated dietary regimen required in the treatment of this genetically determined disease and of the emotional impact on family members living with phenylketonuric children.

Prior to the comparatively recent development of the low phenylalanine diet, most known phenylketonuric patients were severely retarded inmates of institutions.[1] With the availability of treatment, new interest has been focused on ways of identifying new patients as early as possible with a view toward prevention of brain damage through the initiation of early treatment.[2]

The Child Development Clinic, which is supported by a Federal grant from the Children's Bureau through the California State Department of Public Health, was established in 1959 as a clinic for the diagnosis and treatment of mentally retarded children. Over the years its PKU caseload has steadily increased. The clinic staff early noted that the parents of children with PKU reacted to the diagnosis and treatment with overwhelming anxieties, revealing their sense of isolation with the problem. Several parents expressed a desire to meet another parent of a phenylketonuric child and to see another child with the disease.

The staff was also impressed with the parents' difficulties in trying to maintain adequate dietary control and in dealing with their child's behavior. Therefore, the staff considered the question of whether a discussion group for parents might not bring the parents emotional support by providing them with an opportunity to see that their problems were not unique and with further interpretation regarding the disease. It was presumed that in a group of persons with problems similar to their own, some parents might feel less threatened in raising underlying questions than in individual clinic interviews.

After discussing these possibilities, the clinic director and the two social workers serving the galactosemia (also an inborn error of metabolism) and phenylketonuria caseloads initiated a 6-session series of meetings at the hospital for the parents in each of these caseloads. Other staff members agreed to contribute their services as needed. Because of the shortage of staff time and the long distances families had to travel to get to the clinic, the meetings were scheduled only once a month. They were, however, held in the evening to encourage the participation of both parents. Refreshments were provided to make for a friendly, informal atmosphere.

Invitations were extended to the 18 families who had phenylketonuric children under care at the time. Since 8 of the families had more than one child with the disease, the actual number of children under treatment was 25. In three of the families, a sibling of the patient had been institutionalized. Three families had two phenylketonuric children at home; in one family, all three children had PKU. All but two of the patients were age 6 or under, 65 percent being under 3.

Parents from all but two of these 18 families came to the meeting at some time. Five families were represented only once or twice, and two of them only by the mother. One family, living nearly 400 miles away, attended two meetings. Three of the participating families lived about 200 miles from the hospital. Only one family lived within 10 miles of the hospital.

As new PKU patients were identified and came under care, the meetings were opened to their parents. To date, a total of 21 families have participated in group sessions for parents of phenylketonuric children. The average meeting attendance has been 16. All but two of the mothers in the group were still of child-bearing age; five became pregnant during the program's first year. The other members suffered with each mother through her pregnancy and eagerly awaited the verdict as to the presence or absence of PKU in the newborn.

Participation

Despite ethnic, religious, and educational differences, the members of the group quickly became acquainted with one another. They learned about the composition of each other's families, and showed interest in each other's activities and the progress of each other's children. Their common experience with PKU created a strong bond.

While the families were generally represented by both parents, the mothers were by far the more active participants; the fathers tended to talk less though they obviously listened with interest. Typically, a father's passivity in the group seemed to parallel his child-rearing role in the family—leaving the care and discipline of the children largely to the mother. The three fathers who participated more actively than their wives seemed to be the least stable persons in the group. Two who were especially vocal were not the natural fathers of their phenylketonuric child but did not inform the group of this.

The other aggressively participating father was an extremely immature man who continually strove to demonstrate his masculinity by his boasts of how he dominated his wife and children. His wife, although a women of borderline intelligence, was doing an admirable task in rearing her five children despite her husband's frequent unemployment, debts, and general irresponsibility. This family had some status needs met in the group through their child, who, in addition to having PKU, had another rare metabolic disorder and was the object of much interest in the hospital. Somewhat in awe of this, the group sympathized about the double problem and gave the family much support in spite of the father's antagonistic personality. Gradually, as the father saw he was accepted by the group in spite of differences of opinion, he became quieter and his wife became more vocal.

One older couple faced circumstances markedly different from those faced by the other group members in that they had two severely retarded children with PKU who were still living at home at ages 10 and 14. The other members turned to this couple for a kind of parental support and seemed rather confused when this was not forthcoming. They wanted leadership from the husband and at one point suggested that he be their chairman. This seemed to stem not only from deference to his age, but also from a feeling that he had lived with the problem long enough to have some wisdom to offer. He rejected the chairmanship on the grounds that he and his wife really did not belong to the group—since their children were so different, they felt the group could not help them with their problems.

This couple did not return after the first few meetings. However, when they were present, the wife was extremely active, repeatedly asking questions which revealed both the severity of her children's retardation and her ambivalent feelings about them. She listened closely to other members who had placed a phenylketonuric child out of the home, and who while they spoke of their suffering during the separation process also demonstrated that sometimes institutionalization can be an acceptable solution. The older couple has since filed for institutional care. While certainly many factors have contributed to this decision, the group experience undoubtedly opened a way for these parents to examine their ambivalent feelings and to loosen the rigid defenses they had developed.

Content of the Meetings

About three-fourths of the sessions consisted of informal lectures by clinic staff members or invited speakers, followed by informal group discussions. Characteristically, in these highly animated discussions there was an observable shift from the subject at hand (genetic, medical, nutritional, and other aspects of PKU) to daily problems related to child behavior and discipline, particularly in relation to diet maintenance. In one-fourth of the meetings, the social worker led informal discussions in which parents could bring up subjects for the group to consider.

At first the meetings were not very productive; the parents were new to one another and uneasy, obviously disinclined to reveal any deep feeling or examine their own role in relation to the problem. Their first remarks were usually repetitions of questions they had already asked repeatedly in the clinic: When can we take Johnny off the diet? Why are tests for the level of phenylalanine needed so often? What are the chances of having another child with PKU?

The social worker and the public health nurse, who observed many of the sessions, were somewhat surprised at the repetition of these familiar questions, which had been given considerable attention in the individual clinic interviews. The repetitions may partly be explained by the fact that the social worker was new to the group. However, they may also have reflected the parents' insecurity over examining their feelings about being parents of phenylketonuric children.

In later discussions, the parents touched on some deeper fears: of producing children who might continue to add to the perpetuation of a defective gene; of becoming impatient with the constant self-discipline required to maintain consistently the rigid diet; and of being inadequate to the ongoing task and unable to cope with the children as they grew older. Gradually toward the end of the year they exposed the pain of their growing awareness that in most instances the child's condition had been diagnosed too late to have prevented some brain damage from occurring. This awareness came as they loosened their hold on the dietary problem as an expression of their anxieties and after sufficient time had elapsed for them to recognize that in spite of their frequent clinic visits and efforts to enforce the diet and in spite of some evident improvement, their children still showed signs of retardation. The parents also discussed their mounting troubles with diet control and discipline as the child grew older and smarter. As the child learned to get around by himself, he was apt to sneak foods and otherwise test the limits of the parents' disciplinary methods.

In the security of the group, the parents moved to some open expression of resentment about the clinic experiences, resentment they could not express as easily in individual conferences. When asked whether being in the group helped them in ways that attending the clinic did not, some of them feelingly replied that:

1. Clinic people were too busy and could not be bothered by all their questions (this despite 1½-hour clinic appointments, in addition to individual casework interviews and other consultations).

2. In the clinic the attention was all focused on the child; the parents felt wrapped up in anxieties about how well they had managed the diet, how successful the child would perform in the psychological testing, and how low the child's phenylalanine level would be, and therefore tended to overlook or forget their own questions. The group experience offered an opportunity to concentrate on themselves.

The parents then moved to a consideration of a more formal organization. They had been impressed by the Rochester League for PKU, a group of parents who had organized to lobby for national implementation of Guthrie blood testing of all newborn babies to detect phenylketonuria. Part of this move toward more structure was probably a defense against exploring deeper feelings within the group, particularly after the display of hostility about the clinic on which the parents leaned so heavily for help. Also, most of them had by this time established a meaningful relationship in the casework situation. Other factors, such as improvement in the child, had reduced their personal anxieties and family tensions to a point where many felt they could cope with their problems more independently.

However, the movement toward more structure did not get off the ground, largely because no strong leadership emerged. No officers were ever elected. Dependence on the social worker seemed to increase. The social worker tried to interest the parents in groups of parents of retarded children in their own localities, particularly as they began to accept the fact that their children would remain retarded in some degree. This might have accounted for some falling off of attendance in the last two meetings. However, many of the parents expressed a strong desire to continue the group, although not as a formal organization.

The Group Experience

The first series of meetings for parents of phenylketonuric children took place from January through June in 1961. A similar group of parents of children with galactosemia disbanded following its fifth meeting. Experience with the latter group revealed that the members were not as anxiety-ridden as the parents of the phenylketonuric children.[3] Several factors probably accounted for this. The galactosemic diet is much less restrictive than the low phenylalanine diet used in the treatment of PKU. Also, most of the parents of children with galactosemia had lost an infant through death due to the disease and were thus highly motivated to keep their other galactosemic children on the diet. Moreover, almost immediately after treatment is initiated for galactosemia, a dramatic improvement is evident, so that parents quickly see the effects of the diet.

In contrast, the parents in the PKU group continued to exhibit a high level of anxiety, both in overt form and in symptoms of underlying tensions. They protested strongly against the planned termination of the group after 6 months. The social worker agreed to continuance, but suggested the need to explore further the kind of group they wished it to be. Then the members on their own planned a park picnic for July to "tide them over" until resumption of meetings in September. Only five families attended the picnic, but they apparently enjoyed it.

Because of work pressures, the social worker could not hold the planned September meeting, and as each week passed she received more and more requests for the meetings' resumption. Realizing she delayed partly to reinforce her own resistance to continue leading the group because of her ambivalent feelings about its goals and benefits, she made a tentative reassessment of the group's experience. Her first conclusion was that the emotional support of other parents seemed to be *more* rewarding than had even been anticipated. This could be attributed to several factors:

1. A nucleus of parents who met regularly had developed. These parents seemed to be having more difficulties which they were unable to manage by themselves than were those who attended sporadically or not at all.
2. This nucleus consisted primarily of parents whose children had just been diagnosed and put on diet therapy.
3. Some of the mothers in this nucleus were pregnant. They were reassured by contact with families who had already taken the risk or were now risking having another child with PKU.
4. Just prior to the initiation of the group, the PKU caseload had been shifted to a new social worker. The parents were still feeling uncertainty about the transfer. The group meetings with the social worker helped some parents to a quicker rapport in the individual casework relationship. On the other hand, some parents initially used the less personalized group contact to maintain distance from the social worker. Much more testing of the social worker occurred in the earlier sessions than might have occurred had the group been initiated after the transfer of caseworkers had been fully effected.

Secondly, the social worker noted that the educational content of the meetings had made some facts about PKU clearer to the parents. As a result, they had had to shift some of their attitudes, but had not as yet had an opportunity to solidify their newer understanding. For example, the early meetings revealed that the parents largely viewed their children as "sick," partly in order to avoid recognizing the presence or danger of mental impairment, and partly as a result of the clinical description of phenylketonuria as a disease with a specific treatment. The explanation of the disease as a metabolic dysfunction had led them to liken their child to a diabetic child rather than to a retarded child. Not regarding their children as retarded, they were not seeking contact with associations of parents of retarded children.

Increased Understanding

By the end of the first six meetings, the parents were beginning to see that their children were physically well as long as their metabolism was stabilized by good dietary management. They were also beginning to recognize that all aspects of the child's behavior, growth, and development could not be attributed to the fact that he had phenylketonuria, and to distinguish those aspects which were normal patterns of maturation from those which might be accounted for by the disease.

At the same time, the social worker was learning why some of the parents were having difficulty managing their children's diet and why some of the patients were continuing to have high levels of phenylalanine in the blood. For instance, one parent, desiring to let the group know just how bright and clever her 5-year-old son was, revealed breaks in dietary control as she reported how the child awoke long before his parents and got his own breakfast. Two other parents expressed concern about their little girl's refusal to chew foods, although she chewed candy well; and group members responded by telling of their methods of handling similar feeding problems, thus enabling the troubled parents to see that the child's manipulative behavior was unrelated to PKU and helping them to examine their own interactions with the child which contributed to the feeding problem.

Meetings were resumed in October 1962 and held regularly through April 1963, with some dwindling of attendance in March and April. In July, the parents who had attended this entire series met together to discuss the experience and the possibility of continuing it. Saying that they had benefited greatly from the group's support, they asked specifically for further group meetings focused on the general areas of parent-child relationships, with occasional special speakers to keep them up to date on PKU. Their point of view coincided with the social worker's opinion that continuing enlightenment about aspects of normal growth and development and sound child-rearing practices improves parental methods and eases some of the difficulties inherent in coping with the stringent diet regimen.

There was again a picnic during the summer, this time with seven families attending. The meetings were resumed in October 1963, and are being continued as a reinforcement to the clinic's counseling and treatment services.

What the Staff Learned

The outstanding feature revealed by this experience was the parents' woeful inadequacy in the area of child-rearing practices. Confusion, uncertainty, and inconsistency governed the parental management of all the children in these families. Their homes were generally child centered with the parents more often than not manipulated by the children. Consequently, when faced with the difficult task of putting a restrictive dietary regimen into effect, the parents had to take on a new role orientation and become stricter, more consistent disciplinarians.

Inner conflicts may be precipitated in some parents by this necessity to perform in a new and different way. Unresolved conflicts of their own parent-child relationships may be reactivated. Alongside this new stress is the feeling of guilt inherent in the genetic aspect of the problem, which tends to reinforce defense mechanisms of overprotection and denial. Depriving the child of desired foods adds further to the guilt feelings and heightens the difficulties in maintaining firm limits on the child's behavior and diet.

The group experience provided the parents with emotional support by helping them to see that their problems were not unique and by giving them a chance to examine their own as well as their child's needs. It also increased the clinic staff's understanding of how to work with parents of PKU patients, understanding which also has implications for work with parents of children with other types of disabilities.

Physicians and other professional workers have long been advising parents of mentally handicapped children to "treat him like your normal child," without regard to the parents' "normal" methods of child care. While mention is often made of the child's need for firmer discipline, attention is rarely given to the problem this imposes for the parent. The parents of children with PKU appear to represent a cross-section of the families in American culture today, with the child-rearing practices of our current culture. Hence, counseling at the time of diagnosis needs to be concerned with bringing about an awareness that the treatment and rehabilitation of the child will frequently conflict with methods of child management with which the parents feel comfortable.

Normal problems of child growth at various ages and levels of personality development are easily distorted in the parents' eyes by the fact that the child has a special problem such as phenylketonuria. Therefore, guidance and information in relation to children's normal developmental needs as well as to the disease or defect should be provided by all the professional practitioners of the various disciplines involved in the care of the child.

Parents tend to focus on the diet as a means of defending themselves from exploring deeper concerns. Members of the clinic staff unwittingly often strengthened this pattern out of their own anxiety and sense of responsibility for having the child under good dietary control. The group experience helped the staff recognize that more attention should be given to the parents' basic anxieties. Exclusive emphasis on the diet often makes the task of keeping the child on it appear overcomplicated to the parents and misleads them into believing that all the dietary breaks are their fault and are causing great damage to their child. They need to be reassured that some situations are not in their control, and that their humanness is respected. Advice to the parents should be geared toward helping them to understand better their child's normal and special needs and ways of adapting their own parenting behavior to meet these needs. Our experience has indicated that there is more instability in dietary control in families in which the parents are unable to cope adequately with child-rearing problems.

Thus, while established primarily for supportive and educational purposes, the parent group has also provided therapeutic benefits to the parents of children with PKU, for the knowledge gained about them has helped the clinic staff offer services more constructively.

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[1] Bickel, H.; Gerrard, J.; Hickmans, E.M.: Influence of phenylalanine on phenylketonuria. *Lancet*, October 17, 1953.

[2] Koch, R.: Pediatric aspects of phenylketonuria. *In* The clinical team looks at phenylketonuria. (K. Shaw, Sylvia Schild, N. Ragsdale et al.) Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961.

[3] Childrens Hospital of Los Angeles; University of Southern California School of Medicine, Department of Pediatrics: Child development project annual report, 1961–62. Los Angeles, Calif. 1963.

A survey of women in a high income area reveals . . .

FOSTER CARE POSSIBILITIES IN A SUBURBAN COMMUNITY

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THE PATTERN of metropolitan development today—a central city populated largely by low-income families surrounded by a higher income suburban fringe—opens the question of whether the suburbs are potential resources for foster family homes. The tendency has been to recruit for foster parents in lower income areas of the city or among rural families. An exploration of suburban resources is important in view of the dearth in most communities of foster families for children needing placement.

With this in mind the writer undertook an exploratory study involving 60 families residing in the Bethesda and Kensington areas of Montgomery County, Md. This area, a commuting suburb of Metropolitan Washington, D.C., is the highest-income area in the highest-income county in the United States, according to 1960 census figures.[1] Directed to the women in these families, the inquiry focused on their knowledge about foster care and other social welfare programs for children, their experience in caring for other people's children, and their readiness to care for children in cooperation with social agencies.

The findings indicate that social agencies would be well advised to develop active recruitment programs in such high-income suburbs.

The names of the women to be interviewed were obtained from the registry of two Protestant churches. They were between 20 and 60; all were living with their husbands. They thus met the general criteria of social agencies for foster parents. Church registries were used because churches are usually regarded as good recruitment resources. Women from two similar churches were selected in order to avoid a bias associated with a single church without introducing the complications of appreciable religious differences. The study points to the need for further exploratory studies in other communities and with different samples of suburban women.

Since the study was not sponsored by the churches, the investigator telephoned the women for an interview without a prior introduction. As 14 women from each church group refused to be interviewed, it was necessary to talk by telephone with 88 women in order to arrange for the 60 interviews. The women who refused to be interviewed gave various reasons: Employment, otherwise too busy, plans to leave the community, or illness.

An interview guide was developed and pretested. The questions were designed not to seem threatening while eliciting basic statistical information about the woman's prior involvement in caring for somebody else's children, her willingness to work with a social agency in caring for such a child or children, and her expectations regarding remuneration. Questions were also included to elicit information about the interviewee's interests and satisfactions in family living and her views about caring for children who manifest deviant behavior. Some of the statistical questions were held until the end in order to make the interview move more quickly into substantive material.

The first questions were:

1. How long have you lived in Metropolitan Washington? Do you plan to stay 5 years more?

2. How many children do you and your husband have? Will you tell me their sex and their age?

3. Do you have others living in the household?

4. Have you had any experience in caring for children not your own, either related or unrelated children?

5. If so, how did you happen to care for this child (these children)?

6. Did you enjoy the experience?

7. What difficulties did you run into?

8. How did your own children respond?

9. Under similar circumstances would you do it again?

The questions at the end of the interview were:

52. What is your husband's business or profession?

53. Is your husband between 20 and 40 years of age? 40 and 60? over 60?

54. Are you between 20 and 40 years of age? 40 and 60? over 60?

55. Have you ever worked outside of the home in the past? What did you do? How long did you work?

56. Are you planning to work outside of your home in the future?

57. Would you be willing to give up your present employment, or to change your plans for returning to work, if you could earn a comparable amount as a foster parent?

58. Are you involved in voluntary activities outside of your home? What do you do?

59. Do you have domestic help? How much?

60. In what bracket did your family income fall last year in thousands of dollars: $6 to $10? $10 to $15? $15 to $20? over $20?

61. How many sleeping rooms do you have in your home?

62. Would you have additional sleeping space for another child or children?

63. Do you have additional comments that you would like to make?

Suburban women are sometimes referred to as "they" as if they are all alike. These 60 women were 60 different people in widely different life situations. Some were young women dressed in slacks who were trying to keep a small, one-floor house together under the wear and tear of children. Others were living in impeccable homes where it looked as though a messy child never set foot. The difference in education was also wide, ranging from women who had completed high school but never worked outside the home to women with master's degrees augmented by substantial professional experience.

The Metropolitan Washington area is often referred to as a transient area. However, only 2 of the 60 families had lived in the area for less than 1 year, while 45 had lived there for 5 years or more. Ten families planned to leave within 5 years, and 10 were uncertain about this.

Foster Care Experiences

The families were, or had been, deeply involved in child rearing. One young couple was still childless, but the other 59 families had a total of 170 children; 54 had 2 or more children; 51 had 1 or more children under 16 years of age. Fifty-eight of the families were living in single-family dwellings. None had anyone else living permanently with them.

The women in these families had had a variety of experiences in caring for other people's children but none in arrangements made through social agencies. Twelve of the 60 women had already provided foster day care or full-time foster care for children for 4 months or more. One woman had cared for others' children during the day for several years to help finance her husband's college education. One family had an American field service student living with them; another had taken care of a relative's child for several years while the parents were in a foreign country. One couple had lived in the home of a friend and cared for his children after his wife had died.

An additional 28 women had had some, but less extensive, experience in caring for other people's children. This group reported cooperative nursery school experience or visits of extended duration from children of friends or relatives. One woman had given foster day care for a short period.

Responses to questions 6 through 9 indicated that with one exception the arrangements of caring for others' children had worked out satisfactorily. One woman, with a preschool child of her own, had encountered difficulties with a child she took for day care because the child's parents involved her in their fights. Had these intelligent young parents made use of the services of the social agencies in their community, perhaps this arrangement might have worked out for the benefit of the child. As it happened, the arrangement was soon terminated and the foster day-care mother sought work away from home.

Twenty-eight of the wives in these 60 families were under 40 years of age, as were 20 of the husbands. The husbands were either professional persons, businessmen, or government employees in various administrative capacities.

Income and Employment

The families were asked about their gross family income. Twenty-one reported an income of less than $10,000 a year; five of over $20,000 a year. In four out of the five highest-income families the woman was over 40 years old. In no family with an income of over $20,000 a year was the woman working, but in 20 families with incomes under $20,000 the women were working either full or part time.

There were many expressions of financial pressure during the course of the interviews—references to the difficulty of meeting payments on the house, or to not being able to afford even a modest addition to the house. Some of the women interviewed gave the impression that they needed money and would respond to recruitment programs from social agencies directed to the concept of interesting and useful ways of earning money at home.

Of further importance to social agencies in planning recruitment programs with this group of women is their employment pattern. There is a trend for these women to move into employment as their children grow older, a trend which appeared in the sample of 60 interviewees and which is confirmed by employment statistics. However, not one of the 60 interviewees had worked throughout her entire married life and no woman with preschool children was employed full time. Of the total group of women, 11 were employed part time, and 9, one of whom was childless, were employed full time.

With the exception of one woman who was heavily invested in her long-standing career as a teacher, the employed women appeared to have selected their employment to fit their family's needs rather than to carry on careers. One woman was working as an administrative assistant in a doctor's office close to home, another in a similar capacity in a church. A nurse worked on night shift in order to be home with her family in the late afternoon and evening. One young woman worked as a waitress in the evening, when her husband could care for the children. This woman said that she might be interested in caring for other people's children instead of going out to work if this would result in similar earnings. Another woman, who was employed full time in a high grade clerical position, said that she would prefer to care for foster children if she could earn as much as she did on her job.

Fifty-seven of the women had been gainfully employed at some period during their lives and so had had experience with the exigencies of work outside of the home. Sixteen had had work experience in the helping professions—teaching, nursing, and occupational therapy. As regards future work plans, 18 of the women said that they do not plan to work outside of their homes; 6 said they were planning outside employment; and 16 were uncertain. The women planning to return to work gave as their reasons the need for money to finance higher education for their children and an interest in out of the home activities.

Volunteer Activities

The pattern of the women's volunteer services suggests ways that they could be reached by recruitment programs. Forty-five of the women mentioned some volunteer activity. In the main, such activities were centered close to home, and usually revolved around their children's school or their church. The women were contributing time to such child-focused organizations as Boy Scouts and Girl Scouts, and to both child- and adult-focused activities at their church.

Since these women appeared to be living their lives close to home, even when they were working, a foster home recruitment program is most likely to reach them through close-to-home organizations. None of the women served in the programs of the community's social agencies, either as a board member or in any other volunteer capacity. One, however, was a member of a countywide curriculum study committee.

The reporting from this group of women negates generalizations that suburban women leave their own children to be reared by domestic help. Thirty-seven did not employ domestic help. Of the 23 women who did have employed help, 7 had it half a day a week; 14, one day a week; and one each, 2 and 3 days a week. These last two women were both employed full time and had children of school age and older living at home.

Answers to the question of whether or not an interviewee has space to receive an extra person may depend on how ready she is to double up and on her degree of eagerness to receive another person as well as on the actual amount of space available. Twenty-two of the interviewees said that they had sufficient space for another person and 16, that they might be able to make room through some doubling up or different use of rooms. A few women spoke of already needing additional space for their own family and of the financial impossibility of building the recreation room they wanted or converting the porch into another room.

These responses show that there is space available in this suburban area for more children. They also raise the question of whether additional young foster families might not be found if agencies made small loans for housing expansion. Many of the homes in suburbia today are small, but the houses are often designed for expansion. Perhaps agencies should take cognizance of this and stop looking for the almost nonexistent "young couple with a big house."

Attitudes Toward Foster Care

The part of the interview guide designed to produce information on attitudes about caring for the children of others was structured with a sense of progression. Thus the interviewees were asked first to consider themselves as a "sponsor" for a child needing the friendship of a responsible adult, secondly as a foster day-care mother, and thirdly as a full-time foster mother. The questions, and preceding explanations, were:

10. Social agencies are asking families such as yours to do what is called "sponsor" a child. This means taking a definite interest in a child not your own and working with a social worker and the social agency on behalf of the child. This might be a child living in an institution whom the agency believed could profit by some experiences, even brief ones, in a family where he could see a mother and a father working together in raising their children. It might be a child from a one-parent family whom the agency believed needed an experience with a different kind of family living. If you were working this way with an agency to "sponsor" a child, the amount of time requested of you would not be so great. The agency would probably want you to have the child in your home for dinner and to spend the afternoon, say one Sunday a month, but it would want you to keep a continuing contact with the child and to plan to work for a long period of time with one child. The social worker would tell you in advance a great deal about the child and a definite attempt would be made to have you work with a child whom the agency believed could benefit by the contact with your family.

Will you tell me how you think you would feel about working with a social worker from a social agency in sponsoring a child? Is this something that you think you and your husband would be interested in doing?

11. Would you have a preference regarding the age and sex of the child you would work with?

12. Would you be willing to work with a child from a correctional institution?

13. Would you be willing to have a child visit whose manners and habits of dress are somewhat slovenly?

14. If you were doing this service for a child, would you want to volunteer your services or would you want to be paid?

15. What would seem like a fair stipend to you?

16. How do you think that your friends and neighbors would respond to your taking in a child in this way?

17. (For interviewees not currently interested.) Would you be interested at another time?

18. The next type of care for other people's children that social agencies are asking of people is called foster day care—taking care of a child during the day while his parent or parents work. Of course the child would often be one from a one-parent family whose parent needed to work and whom the agency believed could benefit by a contact with your family. If the child were of preschool age, care would be required during the entire day; if he were in school, care would only be required after school hours and probably all day during the summer. Would you and your husband be interested in working with a social agency and a social worker in providing this type of care for a child?

19. Would you have a preference regarding the age and sex of the child?

20. (For those not currently interested.) Would you be interested at another time?

21. If you were providing this type of care, would you want to volunteer your services or would you want to be paid?

22. What would seem to you to be a fair stipend?

23. How do you think your neighbors and friends would respond to your caring for a child in this way?

24. Would you be willing to consider this kind of work as a career for yourself?

25. The other type of care that agencies are asking of families such as yours is 24-hour-day, 7-day-week foster care. Social agencies seek this kind of care for children who for one or another reason cannot live with their own families and whom the social agency believes can benefit by an experience in living with a family where he can see a man and a woman working together to build family life. Would you and your husband be interested in working with a social agency and a social worker to offer this kind of care to a child?

26. Would you have a preference regarding the age and sex of the child?

27. (For those replying in the negative.) Why do you feel that you would not be interested in doing this?

28. Would you be interested at another time?

29. Would you be interested in considering this kind of work as a career for yourself?

30. What would seem to you to be a fair remuneration for this service? The agency would supply the child's clothing, medical and dental care, and personal allowance. You would provide room, board, and laundry, and your service to the child.

31. What would you expect to find rewarding about foster parent work?

32. What difficulties would you expect?

33. How do you think that your own children would respond?

34. How do you think that your husband would feel about having a foster child in your home?

35. How do you think that your friends and neighbors would respond to your having a foster child in your family?

36. Have you ever known anyone who has worked with a social worker and a social agency in caring for a child not her own? How did she enjoy it?

Thirty-seven of the 60 women interviewed expressed some interest in taking responsibility for a child not her own. Of this group, 14 said they would possibly be interested when their children were older or they had a larger house; and 23 expressed a definite current interest in providing child care in one, two, or all three of the programs which were discussed with them. Eight women expressed a current interest in full-time foster family work and four of these women also expressed interest in sponsoring a child and in foster day care. Two women were actively seeking foster day-care work.

Implications for Recruitment

It is, of course, one thing for a woman to express interest in working with another person's child in a cooperative relationship with a social agency; another thing to put this interest into operation; and still another, for her to function successfully. Moreover, although question 34 allowed for the woman's projections of her husband's attitudes, the study included no direct findings on the husbands' opinions. Nevertheless, the women's expressions of interest were impressive.

None of the women were overtly critical about social work or social workers, but they were obviously uninformed about social agency programs. Forty-two of them knew of someone who had provided full-time or daytime foster care for a child, but only two knew how the youngsters had come to the families—in these instances through the juvenile court. As far as they knew, the arrangements had gone well. Thus it would appear that agencies recruiting foster homes, in this suburban area at least, would not be faced with negative attitudes.

Eighteen of the women indicated a current interest in sponsoring children, an activity which might be developed more extensively by social agencies as a means of learning how to work with suburban women and of making them aware of the needs of other people's children. One interviewee said, "I would probably undertake foster care tomorrow if I saw a compelling reason for it, or if a relative's child needed care. I like children." Perhaps the experience of sponsoring a child would make the foster-care need seem compelling. Another woman said, "It has been interesting talking with you; you have started me thinking about things I have never thought about before." Can more be done to start these women thinking?

All the women said that they would expect a sympathetic response from their neighbors if they undertook foster care. This suggests that the neighborhood would be willing to absorb foster children. One woman thought that if her friends saw that she was caring for another child they might become interested in doing the same.

The women did not express moralistic judgments about children from a correctional institution or children with bad manners. The eight women who indicated a readiness to take in a foster child now said that they would work with deviant behavior. They apparently did not have a picture of foster children as little angels.

The women were restricted in their answers to the question about payment for child-care services by their impression that agencies cannot afford to pay much. Many women said that they would not expect a fee for their service but would expect to have the cost covered. However, they were uncertain as to what this cost would be.

Two women did relate the question of payment to the money they could earn in outside employment. One woman with three school-age children said that she would need to clear about $50 per week if she gave up her employment. She thought that then she could care for two preschool children in addition to her own children and said that she would prefer this to work outside the home. The other woman, who will need to return to work to finance a college education for her children, priced her potential earning capacity at $75 per week. She, too, said that she could care for several school-age children. Both these women suggested a foster boarding home rate of about $150 to $200 per month per child—figures not out of line with the cost of institutional care for children, but higher than the usual foster-home rates in most child-placing agencies.

Child-Care Abilities

Another section of the questionnaire was designed to elicit clues as to how these families might function as foster families. The questions in this section were:

37. I am anxious to see how people's feelings about caring for children not their own are related, if at all, to the experiences they have had in raising their own children. What have you enjoyed most in raising your own children?

38. What have you found most difficult in raising children?

39. What do you consider your greatest assets or strengths as a family?

40. What kinds of things do you most enjoy doing with your children?

41. What kinds of things does your husband most enjoy doing with your children?

42. In what ways do your children help around the house?

43. How do you think you would feel about working with a child who is bright but shows the effect of the tough breaks that he has had by being retarded in school?

44. How do you think you would feel about working with a child who is slightly below average in intelligence?

45. How do you think you would feel about working with a child who is not very affectionate, does not show his feelings, and gives the impression of being aloof and indifferent?

46. How do you think you would feel about working with a child who is restless and defiant?

47. How do you think you would feel about working with a child who does some petty stealing?

48. How do you think you would feel about working with a child who is rude and has bad manners?

49. How do you think you would feel about working with a child who continues to wet the bed beyond the normal age for bed wetting?

50. When one or both parents of children who are placed in foster care live in the community, the social agency often believes that the children should be visited by their parents. How do you think you would feel about having the parents of your foster child visit in your home?

Forty-five of the women said that they had found "watching their children's growth and development" the most enjoyable feature of child rearing. Nine women said that they had enjoyed seeing the individual differences in their children. Only three responses were markedly different from these. They came from women who at other places in the interview gave indications of trouble in the parent-child relationship, and who also had said they were not interested in providing foster care.

All of the women said that they and their husbands enjoyed doing things with their children—traveling, camping, games, hobbies, and sports being mentioned frequently. Twenty-nine said their husbands and children enjoyed working and playing together around the house. They described small pleasures. Said one woman, "My husband enjoys popping corn and roasting marshmallows with the children about as much as anything."

Few of the women seemed compelled to paint a completely rosy picture. Forty-eight of them mentioned some problems, the most frequent being problems of discipline. Seven women referred to the fact that their husband's work necessitated his absence from the home or called for frequent moves. Six women mentioned their children's learning difficulties. Twenty-one of the women who mentioned problems said that they did not have any great ones.

In general the women gave the impression that family life was going rather well. Apparently there is a high percentage of families in this suburban area in which the structuring of intrafamily relationships is solid and conducive to reasonably healthy growth in the children. Social agencies might try recruiting foster families in the area with the expectation of finding some healthy families with whom they might work.

While the eight women who expressed interest in foster care said they would be willing to work with deviant behavior, not one was sufficiently self-punishing to say that she would work with all of the kinds of deviant behavior described in the interview. One woman thought that she could work with only four of the types of behavior described, but the others thought they would be able to work with five or six. A restless and defiant child seemed to be the most frightening kind to them; only two women said that they would undertake to work with such a child. No one expressed moralistic attitudes about deviant behavior, the idea being generally expressed that behavior can be changed and that as foster parents they would try to change it by working with the child.

Conclusions

The findings of this study suggest that social agencies would be well advised to undertake foster-home recruitment programs in higher income suburban areas. They also suggest that churchgoing women in such areas might be motivated to sponsor children from institutions or children in critical life situations, and in doing so might become interested in further work with social agencies on behalf of children.

The interview guide produced useful material from the interviewees, not only for determining their possible interest in foster care but also for identifying families having problems in parent-child relationships. Further experimentation with this type of questionnaire guide for interviewing is indicated to test its usefulness as a first screening device in recruiting sponsors and foster parents.

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[1] U.S. Department of Commerce, Bureau of the Census: Maryland—general social and economic characteristics. U.S. Census of Population 1960, Series PC (1–C). 1962.

A voluntary adoption agency improves its services through the . . .

DIFFERENTIAL UTILIZATION OF SOCIAL WORK PERSONNEL

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MOST social and health agencies that wish to improve their services to individuals, whether children or adults, are faced with the problem of a shortage of the kind of highly qualified professional persons they need to carry out those services. This is especially true of adoption agencies, which have often been subjected to criticism for the quality and quantity of service they offer. At the Spence-Chapin Adoption Service, a voluntary agency in New York City, an attempt, beginning in 1956, to improve services by incorporating modern mental health concepts into the agency's structure, policies, and practice ran headlong into the shortage of highly skilled and experienced professional social workers. The result has been a reorganization of the agency's practices for the greater utilization of its highly qualified, professional social casework personnel and a greater emphasis on the training of beginning workers and students.

This change was actually the by-product of a conviction that the anxiety experienced by many adoptive couples in the adoption process could be reduced by continuing attention to ways of insuring as therapeutic a service as possible to the agency's individual clients—adoptive applicants, natural parents, foster parents, and children. The question of how improvements in these directions could be brought about if additional highly qualified social work personnel could not be obtained then had to be faced. Gradually, the agency came to three conclusions:

1. The manpower shortage in social work had to be realistically recognized.

2. Offering to highly qualified social work personnel on the agency's staff increased opportunities for practice in leadership would make it possible to use these key staff members to better advantage.

3. Greater fulfillment of the agency's educational responsibility in social work training and field instruction was inescapably related to the improvement of its services.

These conclusions led the agency to factor out the aspects of the casework process in an adoption-foster care agency which require exceptional casework or administrative skill and those which, under competent casework supervision, can be carried out by students and beginning workers. As a result the agency believes it has achieved: (1) maximum utilization of key administrative and supervisory personnel in aspects of the casework process per se as well as in casework supervision; (2) a multiplier effect on both personnel and services, derived from the training of increased numbers of students in social work; and (3) the development of methods of working with clients which incorporate constructive mental health principles.

The steps to reorganization were based on convictions shared by the agency's board and staff that: New methods of serving clients should be continually explored; these methods must be related to the stage of development and size of an agency and should themselves evolve and adjust to meet changing circumstances and conditions; and efficient caseload management would be crucial in any plan to improve the quality and quantity of service. Thus:

1. A statistical card system was inaugurated with triplicate cards; one for the caseworker, one for the supervisor, and one for the central statistical clerk. This system provides for better caseload management and better administrative and supervisory control of case movement.

2. Additional clerical staff was taken on to provide better departmental secretarial service, thus freeing the casework staff for more complete concentration on casework activities. Case recording was streamlined, changing from the process type to the summary type. Legal and other procedures were studied, revised, and developed into an agency manual.

3. The agency incorporated into its philosophy and practice the concept of screening-in rather than screening-out clients, maintaining at all times an "open door" policy toward people seeking service. A centralized telephone inquiry desk was established for dealing with all community inquiries and referring persons whom the agency cannot help to appropriate community agencies.

4. Three departments were established within the agency: (1) a natural parents department; (2) a foster care department; and (3) an adoption department. This departmentalization was envisaged not only as a way to provide greater efficiency through some specialization and to recognize the varying elements of "imperative need" of different types of clients, but also as a way of providing certain other mental health advantages to be discussed later. The staff's need to experience variety in caseload was insured by periodic transfers of staff members from one department to another.

5. Gradually the number of supervisors in the agency was increased from 3 to 10, the number of students from 2 to 20, and the number of persons beginning their work and graduate study at the same time (called work-study students) from none to 20. The professional performance of the supervisors was strengthened by selected reading from the agency professional library, by agency seminars, by attendance at graduate university seminars and institutes, and by the actual experience of supervising. Appropriate consultants (in anthropology, genetics, law, psychiatry, psychology, and religion) were made available to the supervisory group.

6. A central intake department was established, with the use of highly qualified casework and supervisory-level staff on a rotating basis.

Qualifications of Supervisors

The following criteria were established for selection of supervisors for students and beginning workers:

Personal Characteristics. Most important is a conviction about the importance of service to people and a respect for human dignity. However, supervisors need to guard against overprotecting their students in order not to impede the pace of "learning by doing." In fact, they need to encourage students to take some risks and learn from their mistakes.

Obviously, the supervisor must be fair and equitable with the students and able to function cooperatively with the administrator and other staff members. The supervisor should also have sufficient emotional maturity to have given up feeling entitled to some protection, special treatment, and moods, and thus become free to help others with their duties, needs, or problems, to share experiences with professional colleagues, and to give others the tools whereby they may become as proficient as, or more proficient than, the supervisor himself.

Supervisors need also to be able to help the student to see the client not only individually but also in relation to the family, the community and present-day society.

Professional Characteristics. Supervisors need themselves to have reached a high level in casework ability based on an understanding of theoretical casework dynamics. They must have the capacity to communicate this understanding to others—by example as well as verbally. This implies the ability to generalize from individual cases and experiences—to analyze, synthesize, and integrate. They also need an ability to conceptualize from their life experiences and to use outside reference material imaginatively and selectively in supervision.

Supervisors must also have the ability to teach casework to another whose personality, capacity, and approach may be different from their own, in a manner which will develop security and self-reliance and a deeper understanding rather than fearfulness and uncertainty. This implies a capacity to avoid assuming extensive detailed responsibilities and judgments which should remain with the student.

Supervisors must be able to see and have a feeling of responsibility for the total agency program and caseload, rather than just a series of individual cases, and appreciate the way in which different parts of the organization must work together to carry out the agency function and to meet changing community needs. This implies an understanding of ways of facilitating the integration of casework, administration, research, and community organization.

With the aid of such highly qualified casework-supervisory personnel, the agency has been able to identify the major authoritative and therapeutic elements in the casework process so that these will not be confused in serving the client. Experienced personnel assume either therapeutic or authoritative roles as indicated. Students and beginning workers carry out therapeutic roles to the extent of their knowledge, experience, and capacity without the conflict that a combination of authoritative and therapeutic roles brings.

Intake and Selection

Through the new intake system, waiting lists, with their resulting anxiety for clients, have been eliminated and the better assignment of cases facilitated. Since all clients at this crucial phase of the casework process receive expert casework service from the most skilled caseworkers, assignments to students and to beginning or experienced workers can be made on a basis of extensive knowledge of the individual clients. Not only is this intake experience a good training ground for caseworkers being considered for later supervisory responsibility but it also provides a logical point for supervisors to keep a hand in casework practice. Thus they know what is going on in the community and do not tend to become isolated in an ivory tower, unrelated to changing circumstances in the human condition.

Recently the agency's efforts to offer clients at this period in the casework process the best perspective and skill which the field of social work has to offer have been expanded through the inauguration of a plan whereby selected casework professors from nearby schools of social work do intake—thereby participating in casework practice without the continuing responsibility which other types of casework involve. The agency believes that the close collaboration of school faculties and agency will be mutually stimulating to the faculty of schools of social work and to the agency's staff.

The agency recognizes that human beings cannot wait indefinitely in uncertainty. Therefore, as soon after the intake interview as possible a selection committee composed of supervisors meets to decide, on the basis of the intake interviews and the committee's knowledge of the number and types of children available, which applicants can be encouraged as prospective adoptive parents and which cannot. The couples are notified immediately of the decision so that their uncertainty can be relieved. This selection system also provides for equitable treatment among the clients in that it makes selection a joint decision of experts, and not a decision by one person. Criteria for such selection include many factors related to the couple's ego strengths rather than such arbitrary factors as age or income.

Differential Caseloads

At Spence-Chapin the adoption caseworker does not work with the natural parent whose child is to be placed with the adoptive couple. Thus she is not burdened with the divided loyalty of working with clients with conflicting needs or interests—the natural parent and the adoptive parents. The caseworker for the natural mother works only with her, not with the child and foster parents. With this protection against conflicting interests, the mother can feel assured of the agency's sincere, sustained interest in her as an individual. Natural parents' visits to their children are made at the agency rather than in the home of the foster family, thus reducing the chances of unnecessary entanglements.

In view of the shortage of professionally qualified social workers, it seemed to us that some new methods needed to be developed in the use of personnel with varying degrees of skill. As a result, change in workers is built-in at Spence-Chapin by plan. Some interesting by-products have emerged from our thus forsaking the long-held beliefs that "it is always good for a client to have one worker" and that "it is always detrimental to some extent to have more than one."

For example, appropriate use of different staff members, at crucial stages in the casework process in adoption (intake, home study, supervision, and finalization of the legal process), provides for greater specialization in particular aspects of each process. This diminishes the dependency of the client on any one worker in the agency, for the fate of the client is not entirely in the hands of any one person. It also prevents couples from developing the idea that one particular worker has given them their child.

The agency's aim is not to make the client dependent upon the agency but rather to help him gain additional perspective and to recognize, with increased rather than decreased confidence, his own strengths and capacities as an adoptive parent.

Once a couple has been tentatively selected as adoptive parents by the selection committee, the case is assigned to a beginning worker and the home-study period begins. This period is envisaged not as a period of extended evaluation but as a constructive one of planning for adoptive parenthood. With the caseworker's help, the prospective adoptive parents assess their life experiences and rather than becoming involved in the kind of excessive self-preoccupation induced by long periods of evaluation begin thinking about what kind of child they can value and what they can give to that child.

In other words, instead of spending months looking for the Achilles' heels in adoptive parents, concerned only with their personality, marital, or other problems, the home-study caseworkers work with the most mature elements in the couple with the expectation of placing a child. Couples are not expected to resolve all of their conflicts, but the worker tries to help them to identify and do something about those they can recognize and to learn to live with the others.

If in this home-study period serious problems come to light which might contraindicate placing a child with the couple, the caseworker discusses this with a supervisor who herself seeks to clarify the points in an interview with the couple, leaving the caseworker free to carry out her therapeutic, casework role. Similarly, in the foster care department, authoritative decisions on closing a foster home or moving a child are made by supervisory personnel, leaving the caseworker's role with the family as a therapeutic one.

In the natural parents department, the caseworker also carries an exclusively therapeutic role with the unmarried mother both before and after the child is born. Emergence of legal complications are taken care of by the worker only insofar as these do not conflict with the therapeutic role. When they do, administrative-supervisory participation in the case is arranged for.

Training Responsibilities

Dr. Paul W. Pruyser has recommended that the professional training of social workers be modeled upon the system used in medical education whereby the school and the hospital are integrally related to one another. He emphasizes that the social worker in preparation needs an atmosphere of working social workers, whose faith, doubts, daring, creativity, and risk-taking he can observe and discuss and with whose professional behavior he can identify. He also notes that the agencies stand to benefit greatly in the quality of their staffs' attitudes and work when the presence of advanced students forces staff members into educational and supervisory roles.[1] We have found this to be true at Spence-Chapin.

In 1956, the agency had 2 students in fieldwork; in 1963, it had 20 students from 4 schools of social work and 20 work-study students. Experience has shown that students respond enthusiastically and productively to the agency's high expectations, its encouragement of creativity, and the type of supervision it offers.

Focus of Supervision

Cases are assigned to students on the basis of the client's particular needs and of what the particular student can bring to the situation from his own background and life experiences. The aim of the supervisory program is to help the student start learning immediately with a minimum of anxiety and a maximum development of his strengths. Not only is there individual supervision of students but also group orientation in each department, as well as special seminars, with suggested professional reading.

The seminars focus on areas of specific significance for an adoption and foster-care agency located in New York City and serving a wide variety of clients: (1) sociological-anthropological factors affecting casework; (2) psychosexual growth and development; (3) ego psychology in casework; (4) purposiveness of normal human behavior; (5) ego identity; (6) legal considerations in adoption; (7) psychological growth and development of a child; (8) maternal attitudes; (9) separation and union; and (10) marriage and the family. In these seminars, led by supervisory staff, the effort is to teach the significant concepts which emerge from casework practice rather than to duplicate in any way the educational program of schools of social work.

In individual supervision, there is concentration on what the student can do rather than on what he cannot do, on teaching significant concepts, not acting as "straw bosses" training apprentices. On a planned basis, students may sit in on a joint interview with an experienced caseworker or supervisor.

Each spring, the agency receives applications from students in accredited schools of social work throughout the United States who have completed 1 year of graduate social work education and who wish summer employment. In the summer of 1963, 17 students were so employed from 9 schools of social work. All were outstanding students who performed creditably during their summer employment, and at the same time, we hope, gained knowledge and skill in casework practice from their work in an adoption agency, from the supervision which the agency offers, and from the agency's philosophy, policy, and practice.

In addition the agency employs each year varying numbers of outstanding college graduates who wish to look into social work as a professional field but who, for a variety of reasons, do not wish to attend a graduate school of social work full time. These work-study students work at the agency 4 days a week and attend a graduate school 1 day a week, completing the equivalent of 1 year of graduate social work education in 2 years. The salary for this employment enables the student to finance his part-time graduate education and to maintain himself, without any subsequent agency commitment.

The 20 work-study students now in training come with outstanding academic records from 19 colleges and universities. Without exception, their interest in this work-study program was prompted by a wish to be more independent than full-time attendance at a graduate school of social work would have permitted. Financial need was secondary to a wish to be financially independent of family and of the commitment graduate social work scholarships usually entail.

Through the use of these graduate work-study students, working under professional casework supervision, it has been possible for the agency to undertake and staff an unusually successful demonstration project in foster care. In the last year over 300 homeless children, most of them Negroes or Puerto Ricans, have been taken from well-baby wards of hospitals and placed in long-term foster homes, returned to their parents, or placed in adoption. This project has constituted a significant breakthrough in the problem of children who remain in New York City's hospitals only because they have no place else to go. In view of the manpower shortage in social work, it would not have been possible without the full utilization of both highly qualified personnel and work-study students.

Through the methods just described the Spence-Chapin Adoption Service has attempted to face realistically the shortage of qualified social workers. As already mentioned, our purpose has been to utilize all our personnel—our most experienced as well as our least experienced—in ways most likely to insure a greater quantity and a better quality of service to clients, while adding continually to the reservoir of qualified personnel in the field.

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[1] Pruyser, Paul W.: Existentialist notes on professional education. *Social Work*, April 1963.

Children, in consequence of their *inexperience* and *helplessness,* have a RIGHT to CLAIM the exercise of PATIENCE and *forebearance* towards them. . . . . . . CHILDREN *have a* RIGHT *to breathe the air of heaven.* . . . The RIGHT to have *amusement.* The RIGHT to receive *moral* and *religious* instruction. The RIGHT to *be heard in their own defence,* when they are charged with any *offence* or *crime.* The RIGHT to *weep,* and the RIGHT to *laugh. . . .* Parents and teachers should, in the government of their children or pupils, have strict regard to their *nice* and *delicate sensibilities.* These should neither be *shocked* nor *crushed.* It *is* their RIGHT.

Lyman Cobb in The Evil Tendencies of Corporal Punishment As A Means of Moral Discipline in Families and Schools, *1847.*

A GROUP APPROACH TO PARENTS OF CHILDREN IN TROUBLE

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WORKING with and understanding parents of children in trouble has always been a vital and necessary adjunct to good probation supervision. Inherent in such a concept is an evaluation of the emotional, mental, spiritual, and physical background of the probationer and his family as well as a responsibility to understand the attitudes and values underlying the family's approach to its problems.

Have juvenile courts been working as effectively as they might with the parents of the children who come before them? Convinced that the Montgomery County Juvenile Court (Dayton, Ohio) was not reaching some parents effectively, this court's probation department initiated a pilot project to involve parents more fully in its treatment program for children on probation.

Our realization of the need for a more comprehensive approach in probation supervision was gained by reviewing several of the problems often encountered in trying to reach parents of children in trouble. These are:

1. *Parental unavailability.* Many parents are unavailable during the normal working hours the court offices are open. Usually these are the hours of the father's employment and often of the mother's. Even when the parents are reached at home, interviews are often difficult because of the presence of several young children or other family members. Few mothers of the children we are concerned with can obtain or pay a babysitter or take a few hours off regularly from normal household and child-care duties for office appointments. Ready transportation is often lacking.

2. *Parental resistance.* Many parents, though desirous of helping their child, will not see or cannot see the need for their own participation in frequent casework interviews. They feel that the child is the one who has broken the law and that it is he, not they, who needs assistance. Protesting that they themselves have never been arrested and that they do not understand why their child has encountered conflict with the law, they see the help that is being offered as help being imposed upon them.

3. *Authoritarian image.* Many parents accept the court's authority to detain or to commit, but not to cause changes in their lives. Consciously or unconsciously resenting authority themselves, some find it difficult to accept external controls. They are unwilling to talk in individual interviews about their problems or those of their child out of a fear of being controlled.

4. *The probation counselor's schedule.* In a recent staff work and time analysis made by the Montgomery County Juvenile Court, it was found that a probation counselor in a month's time had approximately 100 hours for direct contacts with probationers and their families. Since a minimum of 50 cases, inves-

tigative and supervisory, comprised the average caseload, simple arithmetic indicated that only 2 hours per case per month were available for both the probationer and his family. Even after classifying cases for time allowances according to their varying needs, the probation counselor is still unable to work as intensively in most situations as the case requires.

5. *The approach.* Although the professional staff of the juvenile court must become involved with the delinquent's total environment, the center of which is the family, the counselor too often deals exclusively with the delinquent. Since the family is the basic unit from which the child draws his underlying attitudes, values, and philosophy of life, failure to invoke processes by which more parents can be reached often results in failure to reach the child's principal source of orientation.

Group counseling is being used today in many kinds of settings,[1] but infrequently with parents of children in trouble. In 1956 the Wayne County Juvenile Court (Detroit, Mich.), under the direction of Judge Nathan Kaufman, applied its techniques in working with parents of delinquent children, but unfortunately the results were not published. Perhaps other courts have undertaken similar programs while still others have been slow to apply the group approach because of a lack of conviction concerning the use of such a method. No doubt the lack of staff trained in group techniques has often deterred the use of a group approach to parents, but the fact remains that group counseling with parents gives some promise that a court staff may reach more of them more effectively if even the present scant knowledge and experience are applied.

Preliminary Planning

In planning our program we found encouragement in the statement found in a description of the group approach to prospective adoptive parents that "the diagnostic picture obtained at the group meeting clarified areas which were obscured in individual interviews"[2] and in the suggestion contained in a treatise by Gisela Konopka that agencies which cannot obtain a group worker "use the professional person whose skill is closest to that of the social group worker: namely, the social caseworker."[3] Since our court did not have a group worker, we determined to proceed according to the latter advice.

Our first step was the formation from within the court staff of a board of advisers, each of whom had 9 or more years of casework experience, to establish the format of the proposed program. Most of these board members, in their years of casework experience, had participated at one time or another in a group project. The board began by examining articles describing the dynamics of various group programs published in professional journals over the past 5 years. The techniques, methods, and limitations revealed in these articles were discussed in relation to their applicability to the proposed parents' program.[4, 5]

At the conclusion of its conferences, the board chose one of its members to serve as director of the project and together with him arrived at specific methods of conducting a program designed to modify uncooperative or poor parental attitudes and to improve the parents' social functioning.

In order to concentrate the project's efforts and to reach a maximum number of parents, it was decided to conduct the program in a public housing development where 14 families containing 15 children under court supervision and 22 adults lived. In only 6 of these 14 families were the natural parents living together. The other eight were broken by death, desertion, separation, or divorce. Five families were headed by a mother alone, two by a mother and stepfather, and one by the maternal grandparents. These 14 families accounted for over 140 registrations with various social agencies, no family having less than 2 registrations.

A room in the housing project was made available for the meeting by the management and equipped with tables and chairs supplied by the housing administrator. By bringing the program to the parents there, it was hoped that more participation would be secured, the court's sincerity of purpose would be made evident to the families, and possible existing barriers would be broken down as the court personnel and parents met together in a spirit of cooperative effort.

Important to the launching of the program was a letter sent by Juvenile Court Judge Frank W. Nicholas to the family heads inviting them to the first meeting. In the letter the judge pointed out that all persons, regardless of calling, realize that young people and their families today face many problems of a complex nature and that because of this it is sometimes helpful for parents to sit down together and talk over matters of mutual concern. A brief outline of the proposed program followed, which was to include a film, discussion, and social hour. The letter ended by inviting each parent to feel free to bring along a friend or neighbor who might be interested in any aspect of the program.

The letter was followed up by telephone calls by the program director and the probation counselor assigned to the district in which the housing project was located. This approach, we believe, had much to do with the favorable response to the invitation and the creation of the friendly but earnest atmosphere which characterized the meetings.

The Program

As a beginning, we decided that one evening meeting a month for 4 months, from October 1962 through January 1963, would give a fair indication of the results to be expected from such a program, would test the degree of parental interest that could be sustained, and would enable the program director and the court to evaluate the possible benefits to be derived from the program. Each meeting was scheduled to last for at least an hour beginning at 7 p.m., more time being permitted if indicated by parental interest.

Each of the meetings was divided into three segments, each consisting of 15 to 25 minutes for the showing of a film, 10 minutes for comments by the judge or other members of the court staff concerning points of interest or emphasis in the film, and 30 minutes or more for group discussion. The films, "The Angry Boy," "The Meaning of Adolescence," "Disciplining of Adolescents," and "Beginnings of a Conscience," were selected for their general interest, pertinence, and the absence of content so pointed as to be likely to cause resentment among the viewers. In selecting these films consideration was also given to the question of whether the homes and families they depicted were enough like the homes of the families represented at the meetings for the audience to be able to identify with them.

To stress the informality of the occasion, coffee and doughnuts were provided and the tables in the meeting room were made attractive through the use of tablecloths and accoutrements. The cost of each meeting was less than $10 and was met through a special court fund donated by private citizens.

Six to eight parents sat at each table along with a member of the court's casework staff who was serving in a volunteer capacity. The caseworker stimulated conversation when necessary, listened attentatively to the parents' discussions, answered their questions, provided them with support in expressing their views, and was available at the conclusion of the meeting to answer any private inquiries.

Immediately after the close of each session, the staff members who served as discussion leaders met with the director and the instructor to discuss and evaluate the events of the evening. Within 24 hours a written summary of the evaluation was submitted to the board of advisers for possible suggestions.

Twenty-one parents, on the average, were present at each meeting, double the number originally anticipated. The women in the 14 families initially involved attended an average of 3 meetings each. Three of the five fathers attended one or more meetings—one, once; another, three times; and the third, four times. The grandfather and a stepfather each attended one meeting. In addition, the parents in five of eight families invited by the participants attended one or more meetings. The other participant-invited guests could not attend because of illness or work schedules.

Parents' Participation

At the close of the formal part of the first session, the parents seemed to relax as they began to discuss the film and the verbal presentation which had followed it. The refreshment period, which came before the group discussion, was an obvious aid in dissipating tensions. A lowering of defenses and a reduction of anxiety were clearly in evidence. Under the guidance of the counselors, all present were given an opportunity to express their feelings and to discuss their children's problems with other parents, and no one parent found it possible to dominate the conversation. At the second session, and thereafter, a number of parents did not wait for the start of the program to discuss their problems but came early to talk about them with the counselors.

Similarly, after the conclusion of the scheduled portions of each session, many parents would stay and continue the discussion or seek private consultation with a member of the court staff.

Sometimes the discussions became charged with emotion. For example:

> Mr. A spoke vehemently of his need to spank his children because of their disobedience, which both he and Mrs. A obviously found extremely frustrating. The methods he described using were harsh to the point of cruelty, but it was evident that both he and his wife were seeking support for their actions. Before the discussions could be channeled to less highly charged areas, other parents entered the discussion, lending them support in the general use of physical discipline but diplomatically pointing out the harshness and the futility of the methods they were using. When these points were made by persons who also were facing frustrating disciplinary problems, Mr. and Mrs. A both listened attentively.

Later when the probation officer called at the family's home, Mr. A, who had never before kept an appointment with him, was there and willingly participated in the interview.

Some Problem Solving

The lack of communication often found in individual casework interviews seemed to quickly disappear in these meetings.

For example:

> Mrs. B, a very self-centered mother, had continually resisted every effort of the probation counselor to help her modify her condescending attitude toward her neighbors and to understand her rejecting attitudes toward her child. Apparently feeling greatly superior to her neighbors, she was highly embarrassed by her child's delinquent acts. After attending the series of group meetings, she freely told the caseworker that she saw much of herself in the films and that she now had a lot of questions about herself to which she was beginning to find the answers.

Such a voluntary statement coming from a mother who could not previously even ask the caseworker questions indicated real progress. Apparently the content and atmosphere of the group sessions had helped Mrs. B to see some of the opposing forces within herself and to find them no longer so threatening that she needed defenses against them.

Another example of problem solving through the group is afforded by Mr. C:

> During the second session, after the showing of the film, "The Meaning of Adolescence," Mr. C raised the question of drinking among teenagers. Although up till then he had been quiet and unrevealing, he took an active part in the discussion as a lively exchange of ideas took place. He began to reveal many of his feelings about alcohol and after a while admitted that he personally had a drinking problem. He apparently had already given some thought to the effect of his drinking upon his job and work habits, but had never seriously considered the effect upon his wife and children. For the first time in the court's acquaintanceship with Mr. C he seemed to be able to discuss this weakness, perhaps partly because several women in the group who had been married to heavy drinkers talked about the effect of drinking on their families.

Mr. C continued to attend the sessions regularly for their remaining 2 months, and during that time, and for at least the several months which ensued until his son's case was closed in the court, he apparently grew much closer to his family and found sufficient support to refrain totally from drinking.

In another family, the D's, group discussions provided the first break in a seemingly impregnable wall of resistance against any kind of counseling. Mr. D had always been unavailable when the probation counselor called at the home, and Mrs. D had usually seemed highly defensive and suspicious of all attempts to secure information from her. The probation counselor learned, however, that Mr. D was a man with considerable hostility toward authoritarian figures, and had at one time served a prison sentence for a felony. While Mrs. D usually gave excuses for his inability to get a job or properly support the family, there were occasions when the probation counselor felt that she really wanted to discuss the family's problems but could not because of the hostility of her husband and her loyalty to him.

> Both Mr. and Mrs. D participated only reluctantly in the first two group meetings, making few comments. However, after viewing the film, "The Angry Boy," Mr. D in sharp tones spoke of the negativism of teenagers today, referring frequently to his own son. As he talked about his son's lack of drive, failure in school, and refusal to help around the house, it became obvious that he was imputing many of his feelings about himself to his son. Some of the parents in the group seemed to sense what was happening and talked of similar difficulties they had experienced with their own children, but at the same time spoke of their own faults. Both Mr. and Mrs. D listened attentively as the discussion progressed and after the session both of them approached the program director to discuss their family problems and other areas of personal interest. While this initial interview was somewhat superficial, it was the first time that either Mr. or Mrs. D had sought help from a court worker or appeared willing to engage in a counseling process.
>
> In a later group session, Mr. and Mrs. D again participated actively in the discussion, with noticeably less hostility. The discussions had apparently helped them to realize that they were more like other people than different and that those present, including the representatives of the court, were genuinely interested in helping them find the right solutions.

For all participants, these informal group meetings seemed to afford a natural opportunity to compare notes and to realize that others were having problems and needed help the same as they. For two women one session led to concerted action. After the showing of the film, "Discipline of Adolescents," these two women began discussing the practice of their preteen and early teenage daughters of scheduling fights with other girls with whom they had become angry. The girls would make appointments to fight at a particular place and time somewhere within the area of the housing project. While only a few girls were usually actually engaged in fighting, many others would gather around as spectators. The manner in which the fights were waged apparently would have done honor to the toughest gang leaders. The police had been called on several occasions, but the clashes had continued and had developed into a major problem for the families concerned and the neighborhood generally.

The two mothers discussing the fights at the group meeting seemed at a loss as to how to control their daughters. During their discussion, however, they resolved to be present themselves at the time and place of a scheduled fight. Other parents promised to keep them informed and to accompany them.

On the next occasion that the girls had arranged to meet in physical combat, the mothers of the two fighters and a few other parents put in an appearance, and the fight was called off. The probation counselor within the district now reports that no scheduled fights have since occurred and that there is every reason to believe this form of conduct has ceased altogether.

Some Values

Most, if not all, of the parents who participated in the project have seemed to appreciate the opportunity it gave them to secure additional insight regarding the origin of a child's problem. This has been evident in such comments as:

"This is just what we needed here."

"I am surprised to see that others have the same problems I do."

"It is good to be able to talk and get things off your chest."

"I feel this has really helped me."

"It is nice to come here because I seldom get to go anywhere and talk with others."

For the first time, many of the parents could accept the court as being an agency of help and the court's staff as possessing some special knowledge and skills. From the court's standpoint, the project has provided an important opportunity of coming to know the parents better through face to face encounters on an informal give and take basis.

The primary purpose of the program was to determine whether or not under court sponsorship parents would be willing to meet and discuss the problems of their children and to find out whether they had the ability to help and to be helped by each other. The experiment indicated that both of these questions could be answered in the affirmative. It also demonstrated that with court and parent cooperation and very little money, programs of this nature can be taken to many parents who want and need help but who for one reason or another cannot or will not accept it in a more formal setting. As a result, the court anticipates conducting more programs of this type in the future. Further, it is the court's intention to systematize and more thoroughly study such programs as they are conducted in order to gather empirical data which will contribute to the knowledge of delinquency prevention, causation, and treatment.

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[1] Fenton, Norman; Wiltse, Kermit T. (eds.): Group methods in the public welfare program. Pacific Books, Palo Alto, Calif. 1963.

[2] Conklin, L., et al.: Use of groups during the adoptive post placement period. *Social Work*, April 1962.

[3] Konopka, G.: Social group work: a social work method. *Social Work*, October 1960.

[4] Spellman, D.: Nucleus and boundaries in social group work: seven propositions. *Social Work*, October 1961.

[5] Matsushima, J.: Group work with emotionally disturbed children in residential treatment. *Social Work*, April 1962.

To enter history, each generation of youth must find an identity consonant with its own childhood and consonant with an ideological promise in the perceptible historical process. But in youth the tables of childhood dependence begin slowly to turn: no longer is it merely for the old to teach the young the meaning of life, whether individual or collective. It is the young who, by their responses and actions, tell the old whether life as represented by the old and as presented to the young has meaning; and it is the young who carry in them the power to confirm those who confirm them and, joining the issues, to renew and to regenerate, or to reform and to rebel.

Erik H. Erikson, "Youth: Fidelity and Diversity" in Youth: change and challenge, *Basic Books, New York, 1963.*

THE UNIVERSAL CREATIVITY OF EARLY CHILDHOOD

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KORNEI Ivanovich Chukovsky, who is now in his 83d year, is practically unknown among Western readers, although he is by far the best known and most widely published children's writer in the history of Russian literature. Highly prolific as an author, translator, and literary historian with deep humanistic roots, Chukovsky has written poetry and stories for preschool children that have appeared in over 40 million copies and in numerous translations. No other living writer for children can match this record. In recognition of his contribution as a translator of Shakespeare, Kipling, Oscar Wilde, and other English writers, he was awarded in 1962 an honorary doctorate from Oxford University.

Chukovsky was already a well-known writer and translator in prerevolutionary Russia, and on one occasion represented the czarist regime in a goodwill mission to Britain. Although frequently in conflict with the official Soviet policy on literature and pedagogy, Chukovsky has managed to maintain an influential role among Russian writers. He has served for many years as director of the Soviet World Literature Publishing House.

Throughout his career as a creative writer and literary scholar, Chukovsky has sustained a scientific interest in children's speech and linguistic development. He is an indefatigable collector of children's witticisms and spontaneous humor. The fruits of his research and speculation on the poetry, speech, and linguistic creativity of preschool children are summarized in his best known work *Ot dvuch do pyati* ("From Two to Five"*), which first appeared in 1924 and is currently in its 16th revised edition.

Miriam Morton and the University of California Press are to be congratulated on making available to American readers this partial translation of Chukovsky's outstanding book. It is based on the 13th edition and includes less than half of the original content, large parts of which are untranslatable since they deal with Russian word play and linguistic analysis which cannot be conveyed in English. To this partial translation has been added a clever and gifted English version of one of Chukovsky's most popular poems, *Tarakanishche* ("The Roach"), rendered with the assistance of Mrs. Nina Wiren, associate in Slavic languages at the University of California, Los Angeles.

Children Are Children

The major impression conveyed by the author's anecdotal material and insightful commentaries is that the life of childhood, its beauties and wonder and delightful illogic, is not much different in the Soviet Union from what it is in the United States. It is possible, for example, that the Russians do try to inculcate a different approach to such a basic "capitalistic" mode of behavior as buying and selling, although Chukovsky's book abounds with quotations that would lead one to think otherwise. Here are a few among many examples:

Three-year-old Irina was convinced that her mother was not "buying" a baby because babies were too expensive. With this in mind, every penny (*kopeika*) that she happened to find on the street, in the yard, or around the house she brought to her mother with the same directive: "Only for buying the baby! Don't spend it on anything else!"

A persistent, teasing old man said to 5-year-old Natasha, about her younger sister: "Give me this little girl as a gift!" "That's impossible!" Natasha objected stolidly. "We paid money for her."

"This church is closed."
"Are they taking inventory?"

Only occasionally do we encounter evidences of propagandistic influences on the child's thought. The following is the only anecdote in the book with a specifically anti-American flavor:

"When it is day here, it is night in America."
"Serves them right, those capitalists!"

Chukovsky believes that optimism, the pursuit of joyousness, and the rejection of suffering and death are almost innate tendencies of preschool children: "Re-creating optimism is one of the great laws of the child's life."

Western readers and child development specialists, alerted to a literature that also stresses the aggressive and asocial behavior of children, will doubtless find this view overly simplified. Still, Chukovsky presents rich anecdotal material which is worthy of attention. He refers to "an osteotuberculosis hospital, where small children, bedridden for years, manage, despite their strained lives, to feel such blessed joy of living that even the pain they endure, year after year, does not traumatize them as it would adults."

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*Chukovsky, Kornei I.: From Two to Five. (Translated and edited by Miriam Morton, with a foreword by Frances Clarke Sayers.) University of California Press, Berkeley and Los Angeles. 1963. xx plus 168 pp. $4.50.

Chukovsky also presents many case examples of ways in which children distort, cognitively and affectively, specific incidents in well-known fairy stories and children's poems so as to censor intimations of pain and death.

Particularly noteworthy are the chapters on "The Sense of Nonsense Verse" and "The Battle for the Fairy Tale" in which the author makes a spirited defense of fantasy in the lives of children and permits himself a number of caustic comments at the expense of "bureaucratic contrivers" and "leftist pedagogues who had, with stupid persistence, banished our great and poetic folklore from the educational experience of Soviet children." Chukovsky himself, along with Maxim Gorki, took a leading role in promoting the more enlightened and more prevalent viewpoint.

In her preface, the translator has the following to say: "In the simultaneous exchange of culture, and invective, between America and the Soviet Union, it is hoped that the translation of this sensitive, instructive, and beguiling book will help tip the scales in favor of culture." Readers of this book will agree that the translator has indeed helped to tip the scales in the right direction.

BOOK NOTES

STATUS FORCES IN DELINQUENT BOYS. Martin Gold. Institute for Social Research, University of Michigan, Ann Arbor. 1963. 229 pp. $6 hard cover; $5 soft cover.

Poverty in itself does not cause juvenile delinquency, but the low status associated with poverty does seem to result in weakened controls against and stronger provocations to delinquent behavior. This is one of the main conclusions based on field research conducted by the author of this report, a part of the Flint Youth Study of the University of Michigan's Institute for Social Research. His study focused on the relations between social class on the one hand, and, on the other, community, school, intrafamily processes, and individual attitudes and behavior.

Drawing largely on interviews with 92 delinquent, white, teenage boys and (separately) their parents and with an equal number of nondelinquent matched controls and their parents, in blue-collar and white-collar families, the author concludes that:

- "Attraction to the family . . . seems to be a crucial variable" in determining a boy's vulnerability to delinquency. Since lower-status families have lower attraction for their children, these families have less control over their children than those with higher status.
- The son's anticipation of his own future status depends both on his father's status (in the community and in the boy's eyes) and on his own school achievement—which, in turn, is much influenced by his father's status.
- Delinquency among middle-class boys stems from factors like those producing delinquency in lower-status boys, but "real" as well as detected delinquency appears to be more frequent among the poor than the prosperous.

The study, which is built on critical analysis of previous research, supports a number of propositions put forward by other investigators, modifies a few, and challenges one or two.

THE RESEARCH COMPENDIUM: review and abstracts of graduate research, 1942–1962. Edited by Margaret Avison, Albert Rose, and Florence Strakhovsky. University of Toronto Press, Toronto, Canada. 1964. 276 pp. $4.50.

Distillations of 398 dissertations and master's research reports submitted over a 20-year period by graduate students of social work at the University of Toronto are presented in this book. In an introductory essay, entitled "Impressions of a Lay Reader," Margaret Avison, who prepared the abstracts, finds them indicating "a disturbing number of communal responsibilities for which no part of the community yet acknowledges steady obligation." Another introductory essay, by Albert Rose, coordinator of research for the university's school of social work, discusses the evolution and function of the research requirement in graduate study as well as some current problems and practices related to it.

The abstracts—2 of doctoral dissertations and 396 of master's theses—report on inquiries into various aspects of health and welfare services, the processes of social work, and community attitudes toward the profession of social work and toward social services.

THE WASTED AMERICANS. Edgar May. Harper & Row, New York. 1964. 227 pp. $4.50.

That public assistance payments have only stalled, not eliminated, poverty is the crux of this work about the people on public assistance rolls. Their poverty the author attributes partially to a faulty system of education, inadequate housing, and racial bias.

Pointing out that no county in the Nation is free of public assistance recipients, the author, a journalist who has been a public assistance worker, portrays the problems for people and program arising from the collision between increasingly high public assistance rolls and the American folk image epitomized by Horatio Alger. In discussing the controversies raging over parents in the program of aid to families with dependent children, he points out that "we have failed to ask penetrating questions about their children"; and he charges that the program has failed to provide the child with the chance to "drop the shackles binding its parents."

The author also discusses the problems of unemployment among youth; the aged and their major worry, how their health care bills will be paid for; the unreasonable expectations placed on untrained, overloaded public assistance workers; birth control, the "whispered solution"; and the estrangement between the "haves" and the "have nots" grown amid suspicion, distrust, exaggeration, and distortion.

The book ends with suggestions that include a massive recruiting drive for public welfare social workers stressing quality as well as quantity.

BRAIN DAMAGE IN CHILDREN: the biological and social aspects. Herbert G. Birch, editor. The Williams & Wilkins Co., Baltimore, Md. 1964. 199 pp. $5.95.

The fruit of a multidisciplinary conference held in Philadelphia in 1962, under the auspices of the Association for the Aid of Crippled Children, this volume presents summaries of eight papers and of the ensuing discussions as a step toward bringing into common focus the diverse professional approaches to the causes and consequences of brain damage in children. Included among the disciplines represented by the authors are pediatrics, psychiatry, epidemiology, sociology, neurology, and experimental, clinical, and social psychology. Among the subjects they discuss are brain damage as a cause of behavior disturbance, strategies for studying perception in brain damaged children, the effects of such children on their families, and some epidemiological aspects.

In the introductory paper, the editor, a faculty member of the Albert Einstein College of Medicine, explains that the concept of "the brain-damaged child" with which the papers are concerned involves a certain pattern or set of patterns of behavioral disturbance, rather than any known pathologic change in the nerve tissues of the brain.

FATHERLESS FAMILIES: a study of families deprived of a father by death, divorce, separation, or desertion before or after marriage. Margaret Wynn. Michael Joseph Ltd., London, England. 1964. 212 pp. 25 shillings.

The gaps, anomalies, and ironies in the legal, economic, and social position of Great Britain's 785,000 fatherless children and their families are stressed by the author of this book against a backdrop of data on poverty among fatherless children and the social and legal rights of the fatherless family, suggested steps toward keeping such a family together, and arguments for recognizing it as a unit numerous enough to be part of social planning. Among the author's proposals are: a fatherless child allowance, payable regardless of the cause of the fatherless state; occupational training plans for mothers of fatherless families; housing accommodations for such families; and adequate day-care facilities.

Among the author's points:

- Want in Great Britain concentrates on fatherless children—half the children in the national assistance program are fatherless.
- The tax and national insurance laws—which discriminate finely among reasons for the father's absence from the family—fail to give some fatherless families either an enforceable right to support or any right to support at all.
- The law makes some arbitrary distinctions that render some fatherless children (for example, of unmarried mothers) underprivileged and exposed to perpetual emotional and psychological disturbances.

SELECTING FOSTER PARENTS: the ideal and the reality. Martin Wolins. Columbia University Press, New York. 1963. 223 pp. $6.

Citing as a foster parent of her day a widow to whom the Governor of Plymouth Colony indentured a boy "for 14 years, shee being to keep him at schoole 2 years, & to imploy him . . .," the author illustrates with such scraps of historical record the development of the various images of the foster parent role of today—as a kind of substitute "own parent," relative, or stepparent, or as a "professional" parent. With the purpose of bringing these diverse images into focus and thus developing criteria for improving, evaluating, and predicting the quality of foster care, the author conducted a series of studies—among child welfare workers, foster parents and their neighbors, and applicant families—which he reports here. Financed by the National Institutes of Health and sponsored by the Child Welfare League of America, the study drew a core of data from two voluntary agencies and nine county welfare departments.

Mapping areas of inconsistency, confusion, and deficiency in the way foster care is being provided, the book's eight chapters turn successively to a research view of foster care, the role of the foster parent, home selection procedures, the profile of the workers' ideal homes, and the evaluation of applicants. A supplement presents tabular material on typical cases, interview schedules, and discussions of the problem of validity and of the implementation of ideas.

The author is associate professor at the School of Social Welfare of the University of California at Berkeley.

WORLD REVOLUTION AND FAMILY PATTERNS. William J. Goode. The Free Press of Glencoe, New York. 1963. 432 pp. $9.95.

The massive movement in the world's changing family patterns toward dominance of the conjugal family over all other types, including the extended family, is the mainstream in this book's analysis of family structure and change during the last half century within the main cultural matrices of the world. Describing and interpreting these changes of pattern in relation to "the sociological processes at work in producing them," the author, professor of sociology at Columbia University, spends a chapter each on family patterns in Sub-Saharan Africa, Arabic Islam, the West, China, Japan, and India. Among the features he examines are practices related to mate selection, age of marriage, fertility, polygyny, divorce, widowhood, and remarriage.

Some of his main points are:

- Orderly processes of social change underlie basic changes in family structure; and the reluctance of some cultures to give up older family patterns comes sometimes from the absence in the emerging social system of viable and fruitful alternates: for example, the taboo against women's working outside the home endures where job opportunities for them are few and wages meager.
- Industrialization and women's entry into the labor force, as in Japan and Arabic Islam, appear to be accompanied by less marital breakdown, traceable perhaps to enhanced freedom in choice of mate and the improved bargaining power of the female.

The author sees the movement to the conjugal family as mirroring the aspirations of growing multitudes toward being able to "choose for themselves" in other sectors of life as well.

IN THE JOURNALS

Juvenile Court Practice

A plea for due process of law in juvenile court proceedings is made by Roger C. Algase in the fall 1963 issue of the University of Louisville's *Journal of Family Law.* ("The Right to a Fair Trial in Juvenile Court.") Among the constitutional protections he names as important are adherence to rules of evidence, such as valid use of confessions; the right of freedom from self-incrimination; the right to legal counsel; and protection from double jeopardy. He cites examples of differing levels of protection afforded in various juvenile courts.

In the same issue standards of conduct for juvenile court judges are discussed by J. Cameron Hall, General Counsel and State Grievance Administrator for the State Bar of Michigan. ("Judicial Ethics for the Juvenile Court Judge.") Focusing on the judicial canons of ethics, Mr. Hall presents examples of their application in daily practice. Among these examples are the use of a social service report, preparation of adoption petitions, the conduct of delinquency proceedings, the judge's role in legislative change, and the publicizing of court proceedings. Mr. Hall also emphasizes the need to give concrete recognition in juvenile proceedings to the same constitutional rights detailed in the Algase article.

Day Care for All Groups

About 99 percent of day-care arrangements for children of working mothers consists of informal arrangements between a mother and another individual—a grandmother, a neighbor, a paid sitter—according to Florence A. Ruderman, discussing some of the findings of the Child Welfare League of America's Day Care Project in the March 1964 issue of *Child Welfare.* One phase of this project has involved interviews with 2,500 mothers of various economic backgrounds in six cities and one rural county, and, according to the author, has revealed that help in making suitable day-care arrangements for children is needed today by many mothers in middle-income as well as in lower-income groups of the population. This, she suggests, poses a challenge to refocus day-care plans to take into account the needs of various population groups.

In the interviews, many working mothers expressed only qualified satisfaction with the arrangements they had made for child care, dissatisfactions being expressed with all types of arrangements by mothers from all socioeconomic levels. Determining the type of day-care arrangement the mothers would prefer was complicated, the author reports, because many mothers did not seem to know what a day-care center was and because of their tendency to say they were satisfied even though they made many critical comments about the arrangements they had made. Moreover, she points out, many mothers revealed uncertainty about how to judge the suitability of day-care arrangements of any kind.

Among the suggestions the author makes is the development of guides to help parents evaluate informal arrangements.

Minor Anomalies in Infants

Multiple minor anomalies in newborn infants may be clues to altered embryonic development which should alert the physician to the possible existence of a more serious abnormality, report three pediatricians in the *Journal of Pediatrics* for March 1964. ("Congenital Anomalies in the Newborn Infant, Including Minor Variations; a study of 4,412 babies by surface examination for anomalies and buccal smear for sex chromatin," by Philip M. Marden, David W. Smith, and Michael J. McDonald.) A major anomaly is defined in the article as one which either affects the physical functions or social acceptance of the individual, and a minor defect, as one having neither medical significance nor visible significance to the individual.

The authors examined 4,412 babies delivered at St. Mary's Hospital in Madison, Wis., from June 15, 1960, to May 30, 1962. Infants were examined on the morning of the first or second day after birth, and a buccal smear for sex chromatin obtained. Deviations classified as normal phenotypic variants after the survey began were not studied in the entire group, report the authors, and interpretation of what deviations constituted anomalies made necessary some arbitrary decisions in the process of classification.

Over the 2-year period, the examinations revealed:

- One minor anomaly or more in 14.7 percent of the 4,412 newborn infants.
- One major anomaly or more in 2.04 percent, including 0.7 percent with multiple major defects. (Over half the infants in the group with multiple major defects were stillborn or died soon after birth.)
- Incidence of chromosomal aberration detected in 4.1 per 1,000 of the infant population.

Only 0.8 percent of the babies with no major anomalies had more than one minor anomaly, as against 6.9 of those with one major anomaly and 56.2 percent of those with multiple major anomalies.

Brain-Injured or Naughty?

Questions as to the appropriateness of the concept "brain-injured" as a disease classification are raised by psychologist Muriel D. Lezak and psychiatrist Henry H. Dixon, Jr., in *Exceptional Children* for February 1964. ("The 'Brain-Injured' Child in a Clinic Population: A Statistical Description.") Noting that the behavior pattern often described as symptomatic of minor brain injury is similar to the behavior of children who are immature, physically active, and resistant to adult authority and standard teaching procedures, the authors hypothesize that in child guidance clinics children diagnosed as brain-injured with no neurological findings are composed more largely of boys, younger children, and children of lower intelligence than children with functional diagnoses.

Finding support for all aspects of this hypothesis in studying the case records of 99 children seen at a child guidance clinic, the authors ask: ". . . is this a disease entity to which young boys of dull-normal and normal intelligence are especially susceptible, or does the concept 'brain-injured' represent an attempt to give scientific terminology to naughty behavior?"

The authors suggest further consideration of this and the corollary questions: What happened to children with "brain-injured behavior" 15 years ago before the concept of minimal brain injury received recognition in the child guidance clinics? What happens to the behavior of these children as they grow older?

Decline of the IQ Concept

"Our individual intelligence tests are dated and hoary with age. . . . in the process of examination, the child who was tested was somehow left out of the picture . . . ." writes psychologist Boris M. Levinson in the January 1964 issue of the quarterly *Mental Hygiene.* ("Quo Vadis I.Q.? Some Reflections on the Current Psychological Scene.") The author, a professor at Yeshiva University in New York City, maintains that tests designed to evaluate intelligence as an entity on the basis of rigid IQ scores should be abandoned.

Pointing out that IQ tests have developed in accordance with a specific era's beliefs, he argues that the growth of psychometric theory in the past 50 years has made the long-standing "unitary index of intelligence" unrealistic and less useful, and thus imposes reappraisal of the clinical functions of psychology.

The abandonment of the IQ concept would have widespread legal, educational, and clinical implications, says the author. Some of these, he points out, are:

- Change in many State laws regarding commitment to mental institutions, and in school procedures for classifying gifted and mentally retarded children.
- The development of criteria for predicting intellectual growth, taking into account examination of specific environmental conditions.
- The development of tests for analyzing personality patterns to provide the clinician with both a predictive and a diagnostic measure.
- Change in school testing programs to measure interest and personality along with educational achievement.

Guides and Reports

THE DONA ELENA PROJECT: a better-living program in an isolated rural community. Lydia J. Roberts. Department of Home Economics, University of Puerto Rico, Rio Piedras. 1963. 113 pp. $2.50. Also available from Photopress, Inc., Gardner at Congress, Broadview, Ill.

Describes a demonstration project in an isolated rural community in Puerto Rico in which a variety of community and home improvements radiated out from a focus on improved nutrition. The project was the prototype for 21 similar projects now under way under the Commission for Improvement of Isolated Communities.

REPORT OF HEALTH SERVICES FOR CHILDREN AND YOUTH OF DALLAS COUNTY—1963. Citizens Committee of the Dallas County Youth Study in cooperation with the Council of Social Agencies of Dallas. Dallas, Tex. August 1963. 170 pp. Free of charge on request.

A collection of reports and recommendations by a consultant team, giving a picture of what should be done to broaden and improve health services for mothers and children in Dallas, the publication covers maternity, child health, nursing, school health, school nursing, mental health, and dental health services and services for handicapped children.

YOUTH IN CONFLICT; Helping Behavior-Problem Youth in a School Setting. Bennetta Bullock Washington. Science Research Associates, 259 East Erie Street, Chicago, Ill., 60611. 1963. 78 pp. $1.50.

Describes teaching techniques used at a special school in Washington, D.C., for boys with severe disciplinary and emotional problems that impede learning. Offers suggestions for adaptation in a regular school setting to help disadvantaged or emotionally troubled students to reach their fullest potential.

AN INTENSIVE CASEWORK PROJECT IN CHILD PROTECTIVE SERVICES. Children's Division, American Humane Association, P.O. Box 1266, Denver, Colo. 1963. 34 pp. 35 cents.

Reporting on a 3-year project begun in 1958 by the Children's Protective Service, Pennsylvania Society to Protect Children from Cruelty, in which intensive casework was given to selected families with multiple problems, this pamphlet contains two principal papers—The Casework Service: Focus and Method; and The Overview Study: Purpose, Method, and Basic Findings—which were presented at the 89th Forum of the National Conference on Social Welfare held in Cleveland, Ohio, in May 1963.

STUDY OF TRAINEES IN MATERNAL AND CHILD HEALTH IN SCHOOLS OF PUBLIC HEALTH. Program Area Committee on Child Health of the American Public Health Association, 1790 Broadway, New York, 10019. 1963. 64 pp. (Mimeographed.) Single copies free on request from the chairman of the Committee, School of Public Health, University of California, Berkeley, Calif., 94720.

Summarizing data compiled from 1947 through 1961, this study presents information regarding the characteristics of 253 physicians, nurses, social workers, and nutritionists who majored in maternal and child health in schools of public health in the United States. Among other information included are data on present employment and salary; trainees' reasons for leaving the MCH field if they did; their opinions of training received and their suggestions for strengthening various areas of training.

HERE AND THERE

Future Child Population

On the basis of fertility levels somewhat lower than prevailed in 1960–63, the child population under 15 in the United States in 1980 may reach 75.7 million, a 35-percent increase as compared with 56.1 million children in 1960. By 1985, children under 15 would number 84.1 million, according to Series B projections of the population as now revised by the U.S. Bureau of the Census. The same Series B projections indicate a 50-percent increase in size of the maternal and newborn infant populations from the middle 1960's to the middle 1980's. Births in the fiscal year 1984–85 are estimated at 6.33 million as compared with the estimate for 1964–65 at 4.26 million.

With growth of the child population as indicated by Series B projections, the ratio of children to adults would increase from 673 children under 15 per 1,000 adults 25 to 64 years of age in 1960 to 737 per 1,000 in 1985, an increase of nearly 10 percent in children to be cared for by adults in their most productive years.

Series B projections are consistent with a fertility rate (number of live births per 1,000 women, 15 to 44 years of age) in 1965 at 110.3, which is below the 1957 peak of 121.2 and about 2 percent below the rate in 1962 (112.1). These projections rest on the assumption that the projected average number of children per 1,000 women at the end of their childbearing will approach 3,100. This rate of completed fertility corresponds roughly to the rate for women who were 60 to 64 years of age in 1940, for whom the rate of completed fertility was estimated at 3,076 children per 1,000 women.

In addition to the Series B projections, other series (A, C, and D) indicate the approximate future levels of population under other assumptions in respect to future fertility. Series A assumption corresponds roughly to a continuation of the average annual level of age specific fertility in the period 1960–63. Since fertility rates have shown recent decreases, the Series A projections may prove too high but are nonetheless instructive.

Series C and Series D projections rest on assumed rates for future fertility which are in turn still lower than those assumed in Series B.

All series share the same assumptions as to future mortality and annual net immigration. In the former case it is assumed that age-sex specific death rates during 1963–85 will decline only slightly; in the latter that the net gain annually will amount to 300,000.

The projections are designed to be consistent with high to moderately high economic activity. And they assume further that future mothers will have their children at the ages mothers did in 1959–61.

The projections are the first of the Bureau of the Census to employ the cohort method of projecting fertility. They supersede projections previously published in 1962 and in 1958, and are reported in "Projections of the Population of the United States by Age and Sex to 1985," *Current Population Reports*, Series P–25, No. 279, February 4, 1964.

A forthcoming "Current Population Report of the Bureau of the Census" will make available the complete results of the revision of projections and detailed description of method and assumptions.

Progress in Day Care

Representatives of 34 State advisory committees on day-care services attended a 1-day meeting in Washington, D.C., in mid-March, called by the Children's Bureau, to discuss the States' progress and problems in implementing the day-care provisions of the 1962 amendments to the Social Security Act. (See CHILDREN, September-October 1962, p. 199.)

At the opening session Esther Peterson, Assistant Secretary of Labor, spoke on the human costs of not having day-care services, emphasizing the importance of providing them in poverty-stricken areas as avenues of escape for deprived children. At the same session Ellen Winston, Commissioner of Welfare, while expressing satisfaction at the progress today of the nationwide movement for day care, pointed out that because of previous neglect the country will have difficulty keeping up with the increasing need.

Reports from representatives of State advisory committees revealed some directions in which the States' day-care programs are moving, usually with the help of Federal funds. For example:

- In *New Jersey*, plans are underway for intensive training of child welfare workers to increase their understanding of the use of day care as an integral part of treatment plans for children and families.
- In *Missouri*, a survey method has been developed for use by volunteers to assess need in their communities for day-care services.
- In *California*, day-care programs are being developed under public welfare auspices, family day-care services to be administered by local county departments of welfare, and day-care centers to be operated by the State Department of Social Welfare.
- In *Colorado*, the Colorado Springs department of public welfare is operating a day-care center for recipients of aid to families with dependent children in which mothers are taught better child care and housekeeping skills.
- In *Connecticut*, the State advisory committee on day care together with State colleges and universities and the departments of health and welfare have developed a comprehensive training program for day-care center operators.
- In *Minnesota*, 9 centers have been started for mentally retarded children since 1961, using State funds, and 30 more are planned.
- In *Oklahoma*, family day-care services are being provided under public welfare auspices, with the provision of casework to the parents—many of whom are teenagers struggling with job training, family responsibility, and low incomes.
- In *Tennessee*, the State welfare department has established four day-care projects in cooperation with local community agencies.
- In *North Carolina*, six day-care centers for migrant children were established in 1963 by local councils of churches and interested citizens, with the State child welfare division provid-

ing the centers with social services and purchasing care for children.

- In *Kentucky*, the Presbyterian school at Buckhorn and the State Department of Child Welfare have established a day-care program for mountain children.
- In *Maryland*, a conference on day care attended by 1,000 people has been followed by an obvious upswing in interest in day care throughout the State.
- In *Illinois*, a day-care center has been established under public auspices to include training programs for professional personnel, and family day-care service is being established in several parts of the State.

In the discussions following these presentations, the participants were especially concerned about the need for:

1. Greater understanding on the part of social workers in general and child welfare workers, especially about the place of day care in child welfare service.
2. Increased public understanding and support of day-care services.
3. A higher degree of cooperation and coordination among official agencies providing day-care services.
4. Finding new ways of financing day care at the State and local level.
5. Developing new ways to recruit and train day-care staff.

In a featured address, Mrs. Randolph Guggenheimer, president of the National Committee for the Day Care of Children, stressed the importance of citizen effort to upgrade the status of day care.

Cystic Fibrosis Programs

During the past 10 years, the number of States which provided some services to children with cystic fibrosis grew from 3 to 26, according to information recently gathered by the Children's Bureau.

Although cystic fibrosis has been recognized as a specific disease entity since 1938, it was not until the 1950's that a few State agencies started to include it in their State crippled children's programs. Among the earliest to do so were Maryland in 1952 and Iowa in 1954.

Provision for the specialized therapeutic management needed by these children, however, was first included in the federally aided programs of a few of the New England States, notably Connecticut in 1955 and Massachusetts in 1957. (See "A Program for Children With Cystic Fibrosis," by Victoria Shannon, CHILDREN, November–December 1961, page 207.) Currently, 22 States have made such comprehensive provision. These States are Alabama, California, Connecticut, Delaware, Iowa, Maine, Maryland, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, and Wisconsin.

Twelve of these States made special provision only since 1960 and of them New York and Delaware have just recently got their programs under way; in Alabama the program is being developed as a pilot project in one county but with the hope of extension to other counties.

In 4 of the 26 States, no formal cystic fibrosis programs have been instituted. Ohio, West Virginia, and Wyoming accept on an individual basis a few carefully selected cases; Alaska includes such cases in its chronic disease program.

Up to July 1963, the cumulative number of cystic fibrotic children receiving services through these 26 State programs was about 1,500 and ranged from 2 in Alaska to 452 in Massachusetts; California provided services to 232 children in the first 9 months of its specialized program which began in 1962. It is estimated that since July 1963, about 300 additional cases have been added to the total cumulative caseload of children seen for the disease through crippled children's programs.

Twenty-four States and the District of Columbia have no provision for cystic fibrotic children in their crippled children's programs. The chief reason given for this gap in services is insufficiency of State funds to cover costly drugs and the specialized services needed by most children with the disorder. Many States which include this disease in their service programs have had funds earmarked for the purpose by their legislatures.

Medical experts have pointed out that most deaths from the disease are due to pulmonary complications and that if the lungs can be kept clear of mucus and free of infection before irreversible damage takes place many children can be expected to live to adulthood and beyond. Experience already has shown that as the result of early diagnosis and immediate institution of a carefully supervised and continuous program of treatment the lifespan of children with cystic fibrosis has increased so that many are now going to school who might have died in infancy. (See "Cystic Fibrosis and Social Stress," by Dorothy H. Andersen, M.D., CHILDREN, January–February 1960, p. 9.)

Just how many children have undiagnosed cystic fibrosis and how many known to have the disease remain untreated is not known. A study of the incidence and prevalence of cystic fibrosis—a cooperative project of the Children's Bureau and the Public Health Service—which has been under way since 1959 is designed to give a clearer picture of the magnitude and seriousness of the problem. (See CHILDREN, November–December 1961, p. 208.) The study will be completed during 1965.

Family Law

Twenty-five persons from law school faculties, national law and social work organizations, and public and private social agencies attended a 2-day conference on research on family law and child welfare services, held in Chicago late in February under the auspices of the Children's Bureau. Purpose of the conference was to identify and plan research about areas of family law that have bearing on the provision of child welfare services, particularly services for mentally retarded children.

A variety of possible topics for inquiry emerged from the ensuing discussions, among them:

- What are the legal precedents regarding guardianship of the person? children of annulled marriages? social agencies' custody rights?
- In custody disputes, what really determines who gets the child?
- In States which require reporting of suspected child abuse, are cases being reported? What happens if they are?
- Whom does the social agency represent at a hearing—a particular child? the agency itself? all the children in the agency's care?
- To what extent are the social values still held which are embodied in specific laws, as, for example, laws concerning illegitimacy?
- What are the legal principles regarding the relative rights of State, children, and parents?

Most research of the type proposed, it was observed, would call for interdisciplinary teams of investigators, including both lawyers and social scientists. The possibility of several law schools setting up research centers for studies in family law was also discussed.

UNICEF Board Meeting

Departing from its custom of meeting in New York, the Executive Board of the United Nations Children's Fund (UNICEF) held its annual policy session in Bangkok, Thailand, in January 1964. The session was held in Asia in order to sharpen the focus on the needs of children in that region and to provide an opportunity for board members to see and appraise UNICEF-assisted projects in the field. Prior to its opening, small groups of board members visited six Asian countries in each of which a different type of UNICEF aid was studied: mother and child health (Indonesia); village water supplies (Pakistan); rural nutrition (India); malaria eradication (Iran); education (Thailand); and social services (Philippines). Their reports together with background papers prepared by the United Nations specialized agencies provided the basis for discussion at the Bangkok meeting.

In addressing the delegates, Julia Henderson, director of the United Nations Bureau of Social Affairs, noted that deep poverty, compounded by rapid population growth and slow economic growth, is the underlying cause of the region's social distress. She and others reported that in Asia:

- There are more homeless, handicapped, and delinquent children than 10 years ago.
- Malnutrition and lack of schooling are priority problems.
- More than half the world's population consumes only a quarter of the world's food supply.
- Less than half the children of primary age are in school and only a small proportion finish the primary grades.

Also on the program was a report and discussion of the Asian Population Conference held in New Delhi late in 1963, which recommended that Asian countries have a positive population policy, geared in with their overall economic and social planning.

Among the policy decisions taken at the session was one to continue UNICEF aid for malaria eradication, reported by many countries to be high on the list of children's needs. Certain safeguards were incorporated into the malaria policy to prevent imbalance between various types of UNICEF aid programs.

The board approved about $23 million in new assistance to 127 projects in 71 countries. More than half of the total was for health services and disease control; about 20 percent for nutrition; nearly 15 percent for education; and the remainder for welfare services, vocational training, and emergency aid.

The board decided that UNICEF may grant assistance to countries for regular evaluation of projects for children and youth which the countries are administering. It also decided on a timetable for global reviews of UNICEF's assistance programs, to be carried out with the specialized agencies concerned with technical advice in various fields.

Maurice Pate, executive director of UNICEF, reported that the agency's income from private sources had risen in 10 years from 2 to 20 percent of total contributions to UNICEF. He pointed out that UNICEF's total income must rise significantly over the next few years to permit the fund to continue its annual commitments at the present level.

In addition to 60 official delegates to UNICEF from 25 countries, the meeting was attended by representatives of cooperating international agencies, of UNICEF national committees, and of nongovernmental organizations having consultative status with UNICEF.

For Migrants

Ways of coordinating health services provided domestic migratory agricultural workers and their families came under discussion at a working conference on migrant health held in Washington, D.C., March 9–10, under the auspices of the Bureau of State Services, Public Health Service. Purpose of the conference was to discuss direct service projects being carried out with Federal funds under the Migrant Health Act. These range from simple sanitation projects to comprehensive health services.

A major focus of attention was the Health Service Index developed by the Florida State Board of Health. This index, an experimental system designed to facilitate referrals of migratory agricultural workers for health service continuity, is an extension of the ZIP code system developed by the U.S. Post Office Department. It is to be tested during the 1964 harvest season in 14 Florida counties which have agreed upon a basic health service program for migrant families.

Among the health services to be provided in these counties are: immunizations, prenatal and post partum services, child spacing service, health education, care of children with rheumatic fever, nursing care of the sick at home, and services to crippled children.

The conferees expressed interest in trying out the Health Service Index, or a modification thereof, along the entire east coast stream of migration if it works out successfully in Florida.

Among other projects described were mobile clinics, family health clinics, and day-care services.

Attending this conference were 47 professional health workers and volunteers from 12 States along the east coast, and Puerto Rico.

Homemaker Service

Evidence that the traditional homemaking tasks performed by homemakers sent into families in which illness is the major problem are often insufficient to meet the needs has prompted the Homemaker Service of the National Capital Area to include personal care as part of the services its 27 homemakers may provide. The new service, which was initiated last fall, is provided under administrative guidelines drawn up in cooperation with all the health services, public and voluntary, in the four counties and two cities which the agency serves and were endorsed by the Committee on Aging of the District of Columbia Medical Society.

The guidelines were prepared by a Special Professional Advisory Committee on Personal Care in Homemaker Service, formed at a meeting of representatives of the health agencies in September 1962, and composed of representatives of the nursing, legal, medical, and social work fields. After being approved by the health agencies and the medical society, they were adopted by the board of the Homemaker Service and put into practice. They include instructions about when personal care can be rendered by a homemaker, the training that the homemaker must have to render such care, the supervision required, and the tasks such care may and may not include.

The guidelines provide that the determination of the patient's personal care needs be made by a physician or a public health nurse and that a public health nurse visit the home to give individualized instruction and supervision to the homemaker in rendering the care. They also provide that the homemaker may not initiate new personal care services, render any service to which the patient objects, or render any service not deemed suitable by the medical or nursing supervisor and the agency.

The personal care tasks included as suitable for a homemaker to perform are similar to those rendered by a nurse's aide in a hospital; the training prescribed is a course in home nursing skills as developed by the American Red Cross and modified for homemaker service, plus continued training by a physician or nurse in relation to specific cases.

Advisory Committees

Two national advisory committees were appointed in early March to help the Children's Bureau in its implementation of the 1963 Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act. (See CHILDREN, November–December 1963, p. 243, and January–February 1964, p. 13.)

The Maternity and Newborn Advisory Committee will advise on maternity care policies, especially in relation to high risk mothers and their babies, program standards, and professional relationships. Its 14 members include 12 physicians, the majority of them obstetricians or pediatricians, a nurse administrator, and a public health social worker. They are: Willis E. Brown, M.D., Little Rock, Ark.; Hazel Corbin, New York, N.Y.; Goldie B. Corneliuson, M.D., Lansing, Mich.; C. William Daeschner, M.D., Galveston, Tex.; Edwin M. Gold, M.D., Brooklyn, N.Y.; Louis M. Hellman, M.D., Brooklyn, N.Y.; Robert A. Hingson, M.D., Cleveland Heights, Ohio; Howard Jacobson, M.D., Boston, Mass.; Lula O. Lubchenco, M.D., Denver, Colo.; Harold S. Morgan, M.D., Lincoln, Nebr.; Lewis D. Polk, M.D., Philadelphia, Pa.; Elizabeth Rice, Boston, Mass.; John D. Thompson, M.D., Atlanta, Ga.; and John Whitridge, Jr., M.D., Baltimore, Md.

The 15-member Technical Committee on Clinical Programs for Mentally Retarded Children is composed of a public health nurse, a specialized teacher, a research nutritionist, a psychiatric social worker, and 11 physicians, including 3 directors of mental retardation clinics. Its members are: John B. Bartram, M.D., Philadelphia, Pa.; Helen L. Beck, Philadelphia; Russell J. Blattner, M.D., Houston, Tex.; Joseph C. Denniston, M.D., Sand Springs, Okla.; Marian M. Holtgrewe, St. Louis, Mo.; Richard Koch, M.D., Los Angeles, Calif.; Marshall D. Kreidberg, M.D., Boston, Mass.; Bert N. La Du, M.D., New York, N.Y.; Alvina M. Looram, M.D., Santa Fe, N. Mex.; Reginald S. Lourie, M.D., Washington, D.C.; Helen Byrne McCormick, Kansas City, Mo.; John C. MacQueen, M.D., Iowa City, Iowa; A. R. Sharp, M.D., St. Louis, Mo.; Richard L. Sleeter, M.D., Portland, Oreg.; and Barbara Jean Umbarger, Cincinnati, Ohio.

For Youth

In the autumn of 1963, an award of an $800,000 grant was made under the Juvenile Delinquency and Youth Offenses Control Act for a youth demonstration project in New Haven, Conn., as a major segment of an ongoing "human renewal" program with more than 50 programs in education, job training, recreation, housing, and related fields. The award will help finance new programs in education, youth employment, and expanded efforts in recreation and correction, in six target neighborhoods.

Also, in the latter part of 1963, grants for setting up training centers for youth workers were $48,627 to Rutgers University and $51,953 to Boston University.

Grants made early this year in support of a major action program demonstrating ways of working effectively with the whole spectrum of community life were $704,071 to Action for Boston Community Development, and $267,460 to the Youth Opportunities Board of Greater Los Angeles. Grants for other action programs made in this fiscal year included $60,693 to the United Planning Organization, Washington, D.C.; $54,000 to Mobilization for Youth, New York City; and for the continuation of planning demonstration programs, $70,067 to Lane County, Oreg.; $23,050 to St. Louis, Mo.; $78,060 to Charleston, W. Va.; and $54,677 to the Mayor's Commission for Youth, Syracuse, N.Y.

Training grants made at the start of 1964, or late 1963, were: for curriculum development, $47,898 to the University of Southern California Youth Studies Center, $66,142 to University of California School of Criminology, $29,808 to the New York Medical College, New York City, $39,268 to the Philadelphia Psychiatric Center, $28,041 to Brigham Young University, Provo, Utah, $29,244 to the New York University Graduate School of Social Work, and $89,682 to the Vera Foundation of New York City; and for workshops, institutes, and seminars, $59,320 to the Federal Bureau of Prisons, $6,480 to the Lincoln Filene Center of Tufts University in Medford, Mass., $6,715 to the Council on Social Work Education, and $29,444 to the University of Utah in Salt Lake City.

. . .

A project to give job counseling and placement to about 700 out-of-school, out-of-work youths 16 to 18 years old from families receiving public aid was begun in February by the Community Council of Greater New York in cooperation with five guidance and placement agencies. A total of $338,000 in Federal Manpower Development and Training Act funds obtained through subcontract with Job Orientation in Neighborhoods (JOIN) supports the project for a year. The five agencies are the Archdiocesan Vocational Service, Federation Employment and Guidance Service, Vocational Service Department of the Urban League of Greater New York, Vocational Advisory Service, and the Vocational Service Center Branch of the Young Men's Christian Association.

The youths—likely to be school dropouts with poor work attitudes and motivation and multiple problems which long unemployment seems to intensify—are referred by the city's public welfare department. They receive direct, comprehensive, and individualized services from each participating agency, with the Community Council acting as coordinator. These services include, in addition to counseling and placement, testing, vocational evaluation, work adjustment training, academic instruction in weak subjects, and followup after placement.

READERS' EXCHANGE

Some Reflections on Adolescent Rebellion

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DRS. Bealer, Willits, and Maida, in their article, "The Rebellious Youth Subculture—A Myth" (CHILDREN, March-April 1964), have offered an interesting challenge to those who refer to the rebellion of the adolescent and the "subculture" of the adolescent group. However, they imply an interpretation of the writings of those who consider *both* a part of the psychology of adolescence that does not seem to me to be quite accurate.

It is characteristic of a successful rebellion that certain things are rebelled against and are abandoned, while other things remain intact. For example, the Thirteen Colonies rebelled against England, but as the new nation took form the law of the land became the English common law. At no time, as far as I know, even in the heat of the rebellion against England did the courts of the Colonies fail to use acceptable parts of the laws established by the English court.

This historical phenomenon relates very much to the adolescent. If his childhood relationship with his parents was satisfactory, the adolescent in attempting to achieve a sense of independence does not rebel against those standards which were instilled in his childhood that are basic to the interliving of our culture. Those standards are a source of primary security for him as he struggles to pass from childhood to adulthood. What he does rebel against are those aspects of the parent-child relationship that bind him to childhood, even though these aspects may be no longer considered important by the parents.

Furthermore, the adolescent makes a great gesture of his rebellion. He talks about it, he wears different clothes from what his parents consider appropriate, he does much as the rebellious people of the Colonies did when they burned the king in effigy. They did not kill the king; they only killed a harmless representation of him to give unity and conviction to their members and a symbolic expression of their goals.

Drs. Bealer, Willits, and Maida are impressed by the questionnaires that indicate that adolescents in answering questions bow to the dictates of their parents. It would be important to study all of those questions to determine which were valid answers in terms of the incorporated standards which the adolescent finds as a source of direction for adult living, and which are those we might anticipate he would in adulthood discard. Two considerations are important in evaluating the latter.

First, most adolescents are very frightened by their revolt against parental standards because they are uneasy about their ability to be wisely selective. When faced with a specific question which involves a pattern of behavior that they recognize as testing whether they will follow the dictates of their parents or will act independently, they are inclined to answer in the framework established by the parents.

One aspect of adolescence that is so confusing is that often the adolescent will verbalize standards that are derivatives of parental standards but much more restrictive. On the other hand, his behavior will be quite to the contrary. The only way adolescents can master the anxiety this contradiction creates is to seek the security of numbers and to express the differences in a group of their own peers. Even when adolescents are in a peer group and confronted by an adult they often will try to answer according to what they believe to be the adults' criteria.

On the other hand, if the results of the questionnaires actually represent the attitude of the adolescent, if he really thinks politically, socially, and philosophically according to the attitudes of his parents, we perhaps should reexamine what we are doing to our present adolescents. If adolescents follow the convictions of their parents in all areas, we cannot anticipate that with maturation they will contribute to an improvement of our culture.

It is usually from the confusion of the adolescent that finally an enrichment of a philosophy evolves. If that were not true, the people who are concerned about the more "liberal" courses given in high schools and universities could be assured that their anxiety was unfounded; that their sons would believe as they the parents believe. If adolescents are already so fixed in their attitudes, we should abandon our courses in philosophy or any others that we feel influence a resolution of the adolescent's confusion, a confusion based upon his need to find his own identity as an individual rather than remaining simply a reflection of his parents.

True, dropouts from high school from families with low economic status probably reflect to a certain extent their parents' attitude toward education. As the adolescent strives to formulate his future goal, he undoubtedly draws on the internalized goals his parents have revealed. One wonders whether in the case of a school dropout it is not important to help him to rebel against his parents' standards in this regard. If the concept of Drs. Bealer, Willits, and Maida that the adolescent is not particularly rebellious is true, we might as well give up on the problems of school dropouts among young people whose parents do not value education.

Psychiatrists cannot argue with sociologists in regard to sociological terms. However, it seems to me that Drs. Bealer, Willits, and Maida start out discussing a subculture and end discussing a culture. I have been taught, in the limited sociological work that I have had, that the characteristic of a subculture is that many mores of the culture are maintained while certain aspects are different. Therefore, a subculture is a branch of the parent culture, rather than something entirely different. By this definition it would seem that the adolescent does have a subculture. Following most of the basic tenets of the culture with which he is familiar, he creates differences.

Drs. Bealer, Willits, and Maida comment that adults introduce new words into their vocabulary and into the vocabulary of the culture. This is certainly true, but adults make a real attempt to make those new words familiar to everyone. Adolescents, on the other hand, have their own language that only by happenstance becomes understandable to the adults who are in contact with them. When an adolescent is asked to define some of the terms he uses, he often finds it difficult to do so accurately without using some of the adolescent's own language. This is reminiscent of the foreigner who can find no English word that quite expresses what a certain word means in his native language.

Drs. Bealer, Willits, and Maida refer to the "lower class culture," though, in spite of some differences in attitudes toward education, many of the values of people of low socioeconomic status are the same as those of the general culture but only expressed differently. Yet these authors do not consider the average adolescent, who places a high value on what other adolescents wear and do, a member of a subculture because he has many values in common with adults.

LECKNER: *What are the specifics?*

In addition to calling attention to a program with a constructive administrative approach to service to families with mentally retarded children who remain in the home, Eleanor J. Leckner's article presents a good case study of planning and implementing an interagency, interdisciplinary demonstration program leading to an established community service. ["The Public Health Nurse in a Program for the Mentally Retarded." CHILDREN, March–April 1964.]

In describing this, the author records these developments particularly in relation to the public health nursing staff, indicating in broad terms the function of nursing in assessment and providing an excellent illustration of pertinent observations and interpretations made by a nurse. Since the role of public health nursing in the currently emphasized programs for care of the mentally ill and retarded at home is not well understood, it is unfortunate that this role was not more explicitly defined and illustrated. Responsibility for "followup" and for providing "emotional support," for example, do not provide a definitive picture of purpose, practice, and result.

Perhaps in referring to the wealth of data in nursing records, which could be used for significant research to answer questions about nursing service to families of the retarded, the author has this more explicit development of role in mind. If so, may she find ways to have the data used.

Dorothy Wilson
Executive Director
Evelyn Gilbertson
Mental Health Consultant
Community Nursing Services of Philadelphia

MORRIS et al.: *Two knotty areas*

Morris, Gould, and Matthews, in their article in the March–April 1964 issue of CHILDREN, do the field of social work a service by identifying the "socal signs" of neglect and abuse which have implications for child protection. ["Toward Prevention of Child Abuse," by Martin G. Morris, Robert W. Gould, and Patricia J. Matthews.]

Now we are ready to move into the knotty areas which have received far too little emphasis—referrals and designation of a "responsible" agency. At this point I would make two suggestions: (1) that referrals be based on the symptom of neglect or abuse, regardless of other symptoms, and (2) that the responsible agency be one which assumes a total responsibility for child protection.

One of the deterrents to a coordinated approach to child neglect and abuse has been that many agencies, assuming a limited degree of professional responsibility, accept such cases on the basis of symptoms other than child abuse. Frequently these symptoms constitute causal factors, such as feelings involved in marital discord, neurotic anxieties, or parental depression, or the impact of the social environment on the family unit. The problems which then arise are: (1) the tendency to minimize the fact of abuse, and to maximize only one or a few of the many causal factors involved; and (2) the fact that a counseling oriented agency is now involved with parents who have, and still may be, violating child neglect statutes.

One questions whether an agency not including child placing and work with courts as an aspect of its basic service can offer appropriate protection to the abused child. Is adequate protection then possible if a situation is hurriedly referred to a protective agency for "instant" legal intervention?

If we are to refer child neglect and abuse cases for service on the basis of the symptoms of neglect or abuse, the "responsible" agency will have to be an agency with its existence based in law and with an "extended concept of treatment" which allows for a full range of services for the protection of children. Such an agency could then offer full "case management" in child abuse cases, thus preventing lags or breakdown in the total protective effort. This would then place one agency in a position of offering the various types of services needed, or of being responsible for obtaining appropriate adjunctive services.

The agency in the most advantageous position to be the agency of case management would seem to be a public child welfare agency—especially if it offers a sound basic child protective service.

Edgar J. Merrill
Director, Division of Child Welfare, Maine State Department of Health and Welfare

PKU: *A casefinding project*

Because of the work we have been doing, the item on the Maryland study on phenylketonuria is of special interest to us. (See CHILDREN, January–February 1964, pp. 36–37.)

We began PKU screening of newborns in August 1961. When the infant is 3 weeks of age we send the parents a PKU kit which includes a letter of explanation, three Phenistix, and an addressed postal card to inform us of the test results. We are getting an 80-percent return.

In the 2½ years we have been screening newborns for PKU in this way, we have found but two positive cases as a direct result of the screening program. These are of great medical interest since they are identical female twins. On the other hand, through the testing of retarded children and adults, we have uncovered 16 previously undiagnosed cases of PKU. Since phenylketonuria is a hereditary condition, we have done extensive pedigree work among these known cases, watching closely relatives who may be pregnant or who are of reproductive age. By this method we have diagnosed three infants still young enough to be benefited by the low phenylalanine diet. Except for these three, the remainder were too old to be helped by the diet even though they are of utmost importance in our casefinding and pedigree work.

Thus we have five infants on the low phenylalanine diet; two who were discovered by our newborn-screening program and three discovered through our pedigree work.

In this work we are being assisted by an investigative team from the Human Genetics and Pediatric Departments of the University of Michigan.

Paul H. Martin, M.D.
Commissioner of Health, Elkhart County Health Unit, Indiana

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

IS SMOKING WORTH IT? 19 minutes; color; sound; loan.

This direct appeal to teenagers and adults to stop smoking uses animated charts and graphs to show facts about the association between cigarette smoking and lung cancer. It presents an unrehearsed discussion by four teenagers of their attitudes toward smoking and a brief interview by a clinical psychologist with two parents who tried to give up smoking—one successfully.

Audience: Teenagers and adults; school administrators; other professional and lay adult members of youth-serving community organizations and clubs.

Produced by: American Cancer Society.

Distributed by: American Cancer Society, 219 East 42d Street, New York, N.Y., 10017. (For loan from local divisions of the Society.)

TESTING MULTIPLE HANDICAPPED CHILDREN. 30 minutes; black and white; sound; purchase.

Presenting some of the testing techniques used at the Brooklyn Jewish Hospital for assessing the individual learning potential of multiply handicapped children with different types of severe handicaps, this film demonstrates with three children: one with severe cerebral palsy and a related speech problem; another with severe visual and auditory impairments; and the third, hyperactive and mentally retarded.

Audience: Professional persons who work with handicapped children; all professionals interested in human growth and development.

Produced by: United Cerebral Palsy Associations.

Distributed by: United Cerebral Palsy Associations, Inc., General Services Department, 321 West 44th Street, New York, N.Y., 10036.

GROWING UP WITH DEAFNESS. 31½ minutes; color; sound; purchase.

Tracing the progress in emotional growth and mastery of speech made over a 10-year period by 12 deaf children who appeared in an earlier film, "That the Deaf May Speak," this before and after presentation shows the relationship of this progress to the children's ability to function adequately in a hearing world.

Audience: Rehabilitation counselors; speech specialists; teacher trainees; casework groups; parents; official or volunteer professional and lay groups concerned with deaf children.

Produced by: Campus Film Productions for the Lexington School for the Deaf.

Distributed by: Ideal Pictures Corp., 53 East South Water Street, Chicago, Ill., 60601.

HEADED FOR TROUBLE. 29 minutes (TV version), and 41 minutes (includes 7½-minute discussion trailer); sound; black and white; purchase or rent.

This discussion film has the purpose of improving police methods of handling juveniles by stimulating discussion of the methods dramatized. It shows both uniformed and juvenile police and juvenile court officers in a suburban area handling three typical juvenile cases—the youngster who is headed for trouble, the juvenile who has committed an offense, and the emotionally disturbed juvenile offender.

Audience: Police officers, PTA groups, juvenile court personnel, general community groups, guidance and counseling groups, and mental health personnel.

Produced by: Potomac Films, Inc.

Distributed by: Public Affairs Committee, 22 East 38th Street, New York 10016.

Photo Credits

Frontispiece, Play Schools Assn., N.Y.

Page 84, National Institutes of Health, Bethesda, Md.

Page 89, Esther Bubley for the Children's Bureau.

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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A DIRECTORY OF SPECIALISTS IN PARENT EDUCATION. Armin Grams and Muriel W. Brown. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 53 pp. Single copies available from the Bureau without charge.

In addition to the names, addresses, and official titles of persons known to be engaged in parent education in the United States or Canada, this directory includes information on their agency affiliations, major responsibilities, and educational background. An index subdivides the alphabetical listing under 42 States and Canada.

PHENYLKETONURIA; a selected bibliography, 1963. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1964. 74 pp. 45 cents.

GALACTOSEMIA: a selected bibliography, 1963. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1964. 38 pp. 30 cents.

These bibliographies list selected references published on two metabolic disorders associated with mental retardation. The one on phenylketonuria extends a bibliography first issued in 1961 to include reports published since 1960. The one on galactosemia is the first compiled by the Children's Bureau on the subject. References are divided into sections devoted to reviews of clinical observations and the pathological, biochemical, and genetic aspects, among others.

YOUNG WORKERS. Their Special Training Needs. Department of Labor, Office of Manpower, Automation, and Training. Manpower Research Bulletin No. 3. May 1963. 19 pp. Copies available from the Office of Manpower, Automation, and Training without charge.

This bulletin reviews the training needs and the status of training for youths between the ages of 14 and 19 years with a high school education or less, who will be entering the labor force during the decade of the 1960's; discusses the special training needs of those who will face more difficult problems because of racial discrimination, physical and mental handicaps, or economic and cultural deprivation; and includes illustrative charts and tables.

THE STEPS AHEAD. Report of a Conference held by the Citizens' Committee for the Fiftieth Anniversary of the Children's Bureau, April 9, 1963. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 408. 1963. 27 pp. 15 cents.

This pamphlet presents a digest of the deliberations of a 1-day conference on the implications of the report of the President's Panel on Mental Retardation attended by 75 participants from a variety of fields and disciplines. (See CHILDREN, May–June 1963, page 123.)

NEW DIRECTIONS IN HEALTH, EDUCATION, AND WELFARE. Background Papers on Current and Emerging Issues. Department of Health, Education, and Welfare, Office of the Assistant Secretary (for Legislation), Office of Program Analysis. 1963. 261 pp. $1.50.

Commemorating the 10th anniversary of the Department of Health, Education, and Welfare, this volume contains summaries of five Presidential messages concerned with health, education, or welfare, and a group of papers on public policy aspects of programs in these fields, selected from the Department's monthly publication *Health, Education, and Welfare Indicators.*

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◀

WHAT DOORS WILL OPEN to allow this young inhabitant of a rural "pocket of poverty" entry into the mainstream of our modern civilization? Will he receive whatever help he needs to develop an understanding of the world in which he lives and the capacity to seize its opportunities? Some of the issues involved in helping families to break the poverty chain are discussed in pages 127–131.

A social worker, with both casework and administrative experience in family and children's agencies, **Alvin L. Schorr** has been with the Social Security Administration since 1958. He spent a year on leave in 1961–62 with a Fulbright Research Fellowship studying government social planning policy and the social services and social security system in France. Among his many publications is the recent book, "Slums and Social Insecurity."

After receiving his master's degree from Boston University School of Social Work in 1952, **Donald C. Harvey** spent 3 years developing a group work program in a home for delinquent and dependent children in Louisville, Ky., where he was also on the faculty of the Carver School of Social Work Missions. In 1955, he assumed his present post in Utica, where he is also on the faculty of Utica College.

With master's degrees from both the Simmons College School of Social Work and the Harvard School of Public Health, **Helen Reinherz** has worked as a caseworker in family agencies and psychiatric clinics. For 4 years she supervised volunteers in the study she describes in this issue. She is working for a Ph. D. in community mental health at the Harvard School of Public Health.

Joseph L. Massimo (left), with a doctorate in education from Harvard, has been working with school dropouts since he went to the Judge Baker Guidance Center in 1958. Previously, he was with the United Community Services of Boston. **Milton F. Shore** (right), who received his doctorate in psychology from Boston University, has worked in a number of child guidance clinics in Massachusetts. He is now with the mental health study center at the National Institute of Mental Health.

Ellen Elizabeth Guillot, social worker and sociologist, was on the North Carolina faculty when she carried out the study described here, but she has since joined the staff of the U.S. Department of Health, Education, and Welfare as supervisory research analyst in the Office of International Surveys within the Office of the Secretary.

In her article **Maud Morlock** fails to mention the special honors paid her at the conference she reports, as a prime mover in the development of homemaker services—one of her major interests in the 21 years she was with the Children's Bureau. Now retired she is on the board of the Homemaker Service of the National Capital Area.

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Will equal opportunity be enough to solve the problems of the poor?

POLICY ISSUES IN FIGHTING POVERTY

ALVIN L. SCHORR

Acting Chief of Long Range Research, Division of Research and Statistics
Social Security Administration

IN OUR CURRENT approach to poor families in this country, those of us concerned with raising the levels of living are substantially embarked upon what might be called a case approach. We are untangling all the threads in the skein of poverty—attitude and environment, individual and family, motivation and opportunity. We muster this understanding in order to turn to the poor, family by family. We are aware that motivation, if it can be stimulated, must find a response in opportunity. But we are working, on the whole, from the family or individual outward. Only the painfully readjusting relationship of Negroes and whites represents a relevant fundamental change. This change, though significant, is not the only one that is required.

Since I am, by training and commitment, a social caseworker, I am convinced of the validity and importance of the case approach. Nevertheless, if we hope to make much progress with poor families, we must ask if the case approach is enough. Many kinds of ideas may be relevant in considering changes that would be desirable in the climate that surrounds poor people or in the structure of our society. To illustrate, I shall deal here with two kinds of ideas that seem profoundly important: the climate of social pressure in which we live and our view of equality.

In preparation for the 1960 White House Conference on Children and Youth, each State submitted a separate report. Curiously, despite some differences in facts reported from State to State, most State reports revealed a marked anxiety in appraising the trends. If an increasing number of women were working or if, on the other hand, women found it difficult to work, the consequence was in either case anxiety. Young people were marrying earlier; the damage that would result was described with alarm. Were the same young people failing to marry and, consequently, producing illegitimate children? States were certainly concerned about that. Moreover, one readily remembers when there was a trend toward *late* marriage—no doubt, a cause for alarm in the 1930's. These examples suggest that we tend to feel and operate under very great pressure.

A Tendency to Prescriptions

We tend increasingly, it appears, to address ourselves to one another in prescriptive terms. Do not smoke cigarettes! Do, even if you are a woman, be creative! Periodical literature has shifted, in the last couple of decades, from fiction to articles and from longer articles to shorter articles. After reading a short story, one can accept the character's solution if one wishes; or one can judge that the character is different from oneself, or after all, fictional—and

---

This article is adapted from a paper presented to the Groves Conference, Knoxville, Tenn., April 15, 1964, and reflects only the personal views of the author.

ignore him. However, an article leaves a reader neither escape route. If it is short, it is likely not even to have qualifying statements. Thus, even the length and form of magazine writing reflects an inclination to order one another's lives.

These two points apply to all of us. How very natural, then, that the helping professions should bring pressure and prescriptiveness to bear upon the families who are our more or less voluntary clientele? Are we in fact exerting such pressure? The problem is recognizable at each of the levels at which we operate.

In face-to-face contact with families, there is a growing tendency to tell them what to do. The evidence that social workers are becoming increasingly prescriptive is assembled elsewhere.[1] Educators are beginning to complain that the pressure in schools is bringing to college a "prematurely dry, harried, anxious undergraduate."[2] Our hopeful recent invention, Peace Corpsmen, and other volunteers are least of all equipped to know the limitation of direct instruction. There is, of course, a wide range of situations in which simple instruction is appropriate. But there is also a wide range of situations in which prescriptions are inappropriate. Today the two kinds of situations are being confused.

Projects and People

When demonstration projects are being developed, insufficient thought is given to effects on people at the project's end. For example, we lavish equipment and staff upon kindergarten children, who then proceed into poverty-stricken first grades. We have learned how these children progress in their preschool experimental phase, but what does the transition do—to personality as well as to learning? We have hundreds of counseling and training projects that sweep people up in a hopeful attempt to improve their circumstances. Many of these projects have a life of one year, during which we count up indications of their progress—training courses initiated, work undertaken, housekeeping improved. But what happens to these people when the project evaporates?

These questions do not simply ask whether conscientiously collected results are accurate. They make a more disturbing point. Projects that are brief or that are not fitted with the greatest care into people's lives may reinforce the most handicapping attitudes of poor people: Lucky today—unlucky tomorrow! It's no use trying because the cards are stacked! To the extent that casual projects even begin to succeed, the pressure of hope is added to the pressure from outside.

Finally, there is the public climate. As cut off as they may be, many poor people read newspapers and see television. The determination, which many of us share, to end poverty is reflected on millions of television screens in poor homes. Some families undoubtedly respond with pleasure. Others are fearful; they cannot be certain what is intended, and they feel the force of the determination being asserted. I happened to visit a high school the day after a metropolitan newspaper described its rehabilitative program. A social worker or public official might find the article admirable. The children saw it differently. They were angry at being called blighted and delinquent. They resented an apparent determination to change them. Nor was the faculty pleased. The newspaper's emphasis on the success of new staff members poked clumsily at a fragile sense of unity in staff relationships.

All this was said by William Blake in two lines, and with more spirit.

> **He who would do good to another must do it in Minute Particulars.**
>
> **General Good is the plea of the scoundrel, hypocrite, and flatterer.**

We live, all of us, under pressure. In this circumstance, we may confuse war against poverty with pressure against poor people. These are not the same thing. On the contrary, it is self-volition that we hope to achieve. Self-volition is a hardier impulse than we sometimes recognize, but it is ironic to suppose that self-volition can be compelled. It would be pleasant to believe that this requires only a tactical change. Obviously, improved techniques and more thoughtfulness with client, project, and public pronouncement would help. But the fact that we need to be cautioned probably reflects a deeper problem. Pressure and prescriptiveness are rooted in our reactions to complexity and change and in our impatience at being thwarted. We may treat the poor worse than we treat one another; we shall hardly treat them better.

Let us leave the question of social pressure, at this point, and turn to our view of equality—which may also influence the outcome of our work with the poor.

Poverty and Alienation

We usually talk as if equality and opportunity were indistinguishable. Historically, equality of opportunity has been our major theme. But European travelers detected a separate theme and, in the nineteenth century, commented upon it with delight and awe. "Nothing in American civilization struck me so forcibly and pleasurably," wrote Harriet Martineau, "as the invariable respect paid to man, as man."[3] In this definition of equality, a man is respected and respects himself no matter what his station or opportunity. But now we have a spate of descriptions that show that we are in rather a different situation. Many of us have been oblivious of poor people or viewed them, when necessary, with scorn. Very many of the poor, for their own part, view the rest of us with resentment or themselves with contempt. The technical term that sums up this development is "alienation."

It is an interesting fact that poverty in Europe does not appear to produce the same degree of alienation. In Sheffield, a gang of teddy-boys listened to the recorded conversation of one of our teenage gangs. The teddy-boys were appalled by the evidences of violence that they heard. In London, because slum houses may be unnumbered, mental health visitors need a device to locate their patients. They are advised to look down a line of backyards. If one backyard is noticeably littered and dilapidated, that is the home of the mentally ill patient. In the worst slums of Britain, in Liverpool and Edinburgh, stoops are whitened and crisp lace curtains hang at the windows—flags of self-respect.

It has been observed before this that alienation need not accompany poverty.[4] It seems necessary, therefore, to understand in what circumstances poor people feel and are accepted as integral to society. The explanations must include a closed class system, which we would reject, and a sense of working-class solidarity, which we have never achieved. The explanations must also include—and this is the point—that society will not move very far or fast without attempting, in some degree, to bring the poorest along. This is precisely where we have made our mistake since the war. We have moved very far and very fast. We have not brought the poor along. And we have the temerity to be surprised at their attitudes and, some of us, to proceed to study them as an alien social system.

Limitations of Opportunity

We are, of course, very seriously embarked on an effort to provide equality of opportunity. It is right to be pleased at this turn of events. But this effort can lead us to the beguiling misconception that equality of opportunity will narrow the gulf between privilege and poverty. The reasons that it will not narrow the gulf are already part of our knowledge.

First, opportunity is related to ability to seize opportunity. Understanding of this fact is the essence of our new sophistication but it presents a thorny problem. In France, for example, aid designed specifically for the poor goes disproportionately to those who need it less than others.[5] In England, an avowed welfare state, housing for those in "housing need" benefits the poor less than others.[6] In the United States too the poorest families tend not to get into public housing.[7] They do not receive financial aids given for education.[8] And we are discovering that those most in need of job training tend not to benefit from the program that Congress has enacted. If one steps back from the detailed problem in each particular program, one general point becomes clear. It is precisely characteristic of those who are poor that they cannot meet entrance requirements and cannot manipulate bureaucracies. On the other hand, those who are not poor are resourceful in these matters. We have so far dealt with this problem by devising better rules from time to time. This misses the heart of the problem: the poorest are the least able to use any rules.

Privileges Beyond Income

Second, in the United States privilege can no longer be audited in dollar income. To know privilege, one must count tax advantages and chargeable business costs, the favors of one's debtors and wooers, and conventions and sabbaticals.

One must count also the distribution of public services. It is generally assumed that public services tend to benefit those who are poor; but it would be useful to perform a balancing-up. Education is the largest expense of local governments. It is a familiar, if uncomfortable, fact that those who are poor get the worst public schools. To take another example, the roads and highways are public but mass transit is largely private. Public roads benefit those who have cars, while the poor pay their way. In short, in the years to come a major share of advancement in standards of living may occur in forms that do not show up in average family income. If we fix our eyes firmly on a dollar standard, we may be congratulating ourselves in the midst of widening inequity.[9]

These first two points test the limits of what we mean by equality of opportunity. If we are talking of nineteenth century opportunity—that is, formal opportunities for cash income—we shall still be left with serious twentieth century inequity. In any case, the final point reaches deeper. In the end, opportunity means jobs, but many are poor who are not available to work. Many are poor because they are old. Are we taking a long view? There are people who will be poor 50 years from now because they have not had adequate homes and schooling in the past 15 years.[10]

Many children are poor because they are socially orphaned. They are born into families in which, although a father has not died, there is no genuine father. For the mothers in many of these families, work cannot be a solution. Work may be an ultimate solution for the children, but are they to be poor meanwhile?

Other people cannot use opportunity because, in one way or another, they are disabled; because they cannot learn a new skill at the time they must; because the effort on which we are embarked will, at its best, fail to reach everyone.

Finally, we must recognize that we are no longer in a situation in which there is likely to be work for *comparatively* unskilled people. We have not yet arranged to provide the number of jobs that will be wanted. On the contrary, in the net we are losing jobs every week. Until we see our way clear to rectifying this, we should not have unreal expectations from occupational training. By the most extravagant estimate, perhaps no more than half the poor families could reasonably improve their situations if suitable training were provided and a connection with a job arranged.

A Commitment to Oneness

For these reasons, opportunity will not unaided produce respect for man, as man. The three D's of alienation—drugs, delinquency, and despair—are already rife. We face the prospect that the gulf between the prosperous and the poor will widen. The statistics of poverty will count fewer of the untrained, but the remainder will be familiar—the aged, the families headed by women, the less well (though better than now) educated. These will be the new (or still) alienated class—smaller, perhaps, but ever more cut off.

We shall pursue the business of being one Nation, or we shall be divided. The objective of achieving an integrated society is equivalent in importance to that of wiping out poverty. It requires measures of its own. What might they be?

The present attack on poverty moves in the right direction. It sets out to commit the Nation to oneness. But clearly we are required to make this commitment on a new scale. One opportunity for such a commitment lies in our ability to produce goods at a continually increasing rate. We might, then, declare a moratorium on self-aggrandizement among the prosperous. That is, for the next 10 years we might undertake to invest the *annual increase* in Gross National Product in our own poor people and, although this is another question, in the poor people of the world.

In the first year this would amount to $20 billion, perhaps more—assuming a net increase of GNP over population. Does the figure seem fanciful? If we provided public assistance for children at the less than adequate level at which we now provide it for old people, we should be spending $4.5 billion more on public assistance alone.[10] And we must think of much more than public assistance—education, medical care, housing, job training, social security, and so forth. A moratorium would move us to think in the magnitudes that are required to abolish poverty, but it would do more. All of us would be investing potential goods in the effort rather than only sentiment. More important, a moratorium would give us a symbol for what has not so far been brought into focus—an integrated society.

It does not seem appropriate to attempt to spell out the mechanics of a moratorium. A few observations may be necessary, however, to avoid an appearance of naivete. A moratorium need not interfere with self-advancement. It does not refer to normal profits and salary raises, but to the additional 3 or 4 percent of goods and services that our economy can produce each year. Nor does it refer to goods that must be allocated to actual population growth. A moratorium would probably require no management devices that we do not already extensively use—that is, control of taxes, money, and credit.

We might, in the end, be giving up very little: It may be a necessary condition of long-range advance that the poorest be given a radical step toward adequacy. This point has been made by Gunnar Myrdal.[11] Furthermore, I am convinced that to those of us who have a decent income the continually rising standard of living brings no satisfaction. We should be relieved and delighted to substitute for a new refrigerator or a second television set, a sense of commitment and community.

Organization of the Disadvantaged

Let us turn to a second measure or series of measures that may assist in achieving an integrated society—more aid and encouragement to poor families to organize for their own purposes. Here, at any rate, we have an objective to which we have given lip-service. Some work runs aground on middle-class assumptions and language. Social agencies are now keenly aware of this problem. Some work runs aground because those who attempt it have ulterior motives. They seek citizen participation in an area that is to be cleared for urban renewal. Often poor people suspect—out of prior experience—that they are only to be used for someone else's purposes. The suspicion may preclude communication even when it is mistaken.

But there is the beginning of other work that is more successful. Civil rights groups such as CORE and SNCC started to move forward when, turning their backs on charitable objectives, they began to operate out of self-respect and self-interest. Therefore they have paid rather little attention to public assistance recipients and public housing residents. Now, however, on the East coast at least, demonstrations for more liberal assistance and better housing have been organized among the poorest Negro groups.

The best of the organized community efforts to deal with juvenile delinquency also attempt to assist poor people in organizing for their own ends. To be sure, Mobilization for Youth has a more difficult problem than CORE. Though conscious that hidden motives can destroy its usefulness to poor people, MFY must nevertheless keep minimal peace with the Establishment. Even the attempt is hopeful, but a sound resolution of this problem has yet to be worked out.[12]

The problem of self-organization among poor white people is, in a way, more acute than among poor Negroes. Poor white people have no comparable movement and they are losing even the advantage that a white skin gave. If they are not reached in some other manner first, they may be candidates for a *White* Muslim movement.

At the core of the problem of stimulating self-organization is the anxiety that it provokes in many of us. Where militant organization takes place, it proves profoundly unsettling to the administrators who are involved. One may wonder where self-organization will end, once it begins. Research in the civil rights movement teaches something about this. It has been observed that the crime rate among Negroes drops sharply where protest action begins.[13] The moral is clear. We have not a choice between tension and peace. We have a choice between tension that is constructive and tension that is destructive.

In Summary

To sum up, while the case approach is sound and necessary, other issues are also involved. As we are all under pressure, we may—under the delusion that we are pressing against poverty—exert pressure against poor people. Our techniques are powerful and may lead us, for a time, to believe people manipulable. But in the end we shall learn the latent lesson of all fables: Seduction works beter than force.

Further, equality of opportunity is very far from full equality. It cannot, alone, promise us an integrated society. We cannot any longer expect to come to this by accident—and time runs out. We have permitted segregation to escalate into the situation of the 1960's. We dare not wait to see into what situation alienation will escalate. We require an integrated society and we must seek it for itself.

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[1] Schorr, Alvin L.: The trend to Rx. *Social Work*, January 1962.

[2] DeVane, William C.: Address to the Association of American Colleges at Washington, D.C., January 14, 1964.

[3] Martineau, Harriet: Society in America, Vol. III. Saunders and Otley, London. 1837.

[4] Cooley, Charles Horton: Social organization. Scribner, New York. 1912.

[5] Girard, Alain; Bastide, Henri: Enquête de l'INED sur l'action sociale des caisses d'allocations familiales et le salaire unique. *Information Sociales.* UNCAF, Paris. Mars 1958.

[6] Schorr, Alvin L.: Slums and social insecurity. Thomas Nelson & Sons, London. In press.

[7] ———: Slums and social insecurity. U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of Research and Statistics. Research Report No. 1. 1963.

[8] West, Elmer: Financial aid to the undergraduate; issues and implications. American Council on Education, Washington, D.C. 1963.

[9] Titmuss, Richard M.: Income distribution and social change; a critical study in British statistics. Allen and Unwin, London. 1962.

[10] Orshansky, Mollie: The aged Negro and his income. *Social Security Bulletin*, February 1964.

[11] Myrdal, Gunnar: Challenge to affluence. Pantheon Books, New York. 1963.

[12] Brager, George: Organizing the unaffiliated in a low-income area. *Social Work*, April 1963.

[13] Solomon, Fredric; Walker, Walter L.; Fishman, Jacob R.: Civil rights activities and reduction in crime among Negroes. Paper presented at the meeting of the American Orthopsychiatric Association, Chicago, Ill., March 20, 1964.

FROM A STATE HOSPITAL TO A CHILDREN'S INSTITUTION

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SINCE 1959, The House of the Good Shepherd in Utica, N.Y., an Episcopalian-founded institution which serves 48 children of all faiths, has provided transitional care to 17 youngsters who have been patients at Crane Hill School, the 70-bed children's unit of Marcy State Hospital. These children have been diagnosed by the hospital psychiatrists as no longer requiring hospitalization, but as still in need of a group care placement to prepare them for adjustment to life in the community.

Differences of opinion exist as to the need for "halfway houses" between the State hospitals and the community. Lauretta Bender, psychiatrist of New York's Creedmoor State Hospital, has called "halfway houses" "halfway programs."[1] She has maintained that any child who is ready to leave the hospital, except those over 16 who should be on their own, should be going home. She maintains that if hospitalized children who cannot be placed in foster homes are placed in an institution as a halfway station to the community, they are likely to stay there and the institution to become filled with hospital children. Our experience has not borne this out.

The House of the Good Shepherd became involved in this experience a year after it had been transformed from a large congregate institution to a small cottage type institution for the care and treatment of children with emotional problems. Its board had gradually come to accept the fact that income maintenance programs under the Social Security Act, the lengthened life expectancy of parents, and the prevalent use of foster family care had eliminated the need for institutional care for large numbers of normal children. The change was made after an extensive survey revealed the need for an agency providing residential group care for children with emotional problems not requiring hospitalization but unable to achieve a satisfactory adjustment in the community. A large number of teenagers were found to be in need of such care.

The institution was moved to a new plant of four self-sufficient cottages, each of which houses 12 children and an administration building including offices, rooms for individual therapy and a gymnasium. Intake policies were revised to focus on children with emotional problems who are healthy enough to participate in community activities. The use of community resources, such as schools, churches, the Boys' Clubs, the Boy Scouts, the Girl Scouts, and the YWCA and YMCA, were made an integral part of the treatment plan. Three full-time social caseworkers, a part-time psychiatrist, and a part-time psychologist were added to the staff, as well as a trained recreation director.

The Decision Making

The psychiatric consultant, a key staff person in any institution serving emotionally disturbed children, was during this transitional period director of the children's unit of Marcy State Hospital. At one of our staff meetings he introduced the idea of our accepting children from the hospital. This suggestion prompted varied reactions on the part of staff members. Among the many questions raised were:

1. How would the children now in residence accept the hospitalized child?

2. Would the hospital children form their own peer group?

3. How would the community schools accept these children?

4. How would the children react if the other children ostracized them?

5. If a child is ready to leave the hospital, why does he have to be placed in another institution?

The same questions asked by staff members were raised by members of the agency's board. Members of the board's social service committee went with the director to the children's unit of the hospital and talked with members of the hospital staff. The committee learned that there were psychotic and neurotic children in residence, but that the diagnosis of the majority of the young patients was primary "behavior disorder." They were informed that the hospitalized children were of normal intelligence but had been unable to control their basic impulses and so had to be removed from the community.

The social service committee also learned the following facts about the children's unit at the hospital. The treatment of the children consists of helping them to understand as far as possible the dynamics of their behavior and to work toward strengthening their egos, thereby helping them to adjust in a more satisfactory manner to the world in which they must live. The various disciplines involved in the team approach are brought into play—psychiatry, psychology, casework, and recreation. At the time the child is ready for discharge he may need a period of convalescent care, as do many medical patients ready for discharge from hospitals. Because of the shortage of foster homes, as well as of the fact that many children cannot accept a foster home placement, discharge planning for a child can be most difficult. If a satisfactory discharge plan has not been completed by the time treatment goals are reached, regression may result.

It became clear that the basic difference between the child who was admitted to the hospital and the child who was being accepted by our agency was essentially one of degree of emotional disturbance. Our approach to treatment—the team approach—paralleled hospital treatment, but on a less intensive basis.

Impressed by these facts the social service committee recommended the acceptance of children from the hospital. After considerable discussion at a number of board meetings, the board approved the committee's recommendation.

For a year or so after the first hospital child was admitted questions were raised at board committee meetings as to how this phase of our program was progressing and whether hospital children created any specific problems in the institution. The director frankly presented for discussion any untoward incident which had occurred, but he was always able to reassure the group that the program was working well. After about a year and a half, the fact that the institution served children from the State hospital was taken for granted and no further reassurance was necessary.

The Procedures

A referral from the hospital usually reads along the following lines:

> It is the opinion of the staff that X would benefit from a group placement as soon as possible since he no longer needs hospitalization. We feel that group placement is preferable to foster home or family care placement. X still has some difficulty with undiluted adult relationships, especially with parent substitutes. We would hope to encourage independence. X needs the support of peer groups to encourage the feeling of adequacy and social participation. Further growth at the Children's Unit is not possible. A less structured setting is indicated in order to reach full potential.

The agency does not request such children. The referral is initiated by the hospital caseworker who contacts the agency's intake worker. The hospital worker sends along a brief summary of the child's history for presentation and evaluation at the agency's intake conferences.

These intake conferences are attended by the agency's professional staff, the consulting psychiatrist, and the school social worker from the public school system. The school social worker is invited since most of our children go to school in the community. Intake decisions are made on the basis of the child's problems and the makeup of a cottage group. The school social worker discusses the problems of the children being considered for admission with the school guidance counselor and school administrators. In some cases, especially when the advisability of accepting a particular child is questioned, the hospital worker is invited to an intake conference.

When the decision is made to accept a child, a formal written referral is requested from the hospital, and preplacement visits by the child to the institution are required. At the time of admission, each child is assigned to a caseworker. The hospital requires biannual reports of each child's progress in The House of the Good Shepherd.

The agency and the hospital established a policy whereby any child accepted for admission to the institution would be regarded as being on "convalescent care." Thus, if a child proves unable to adjust to our setting, he can be returned to the hospital without the usual admission procedure. No child is officially discharged from the State hospital until he is ready to return to the community. Decisions for discharge are made in a joint conference between hospital and agency staff.

Some Successes

The first two children we accepted were boys, Bill, aged 9, and Tom, aged 12. Both these boys were rather outgoing and seemed to adjust easily to our setting. They spoke freely of their hospital experience, and this had no startling effect on the other children. However, after what we call the "honeymoon period," Bill and Tom began to display aggressive behavior. They had not been accepted by their peers and so became "loners." Both boys had appealing personalities and were liked by their houseparents, who did not consider their behavior alarming; in fact, they regarded it as similar to that of the other boys.

When the first adolescent was admitted from the hospital, new problems arose. This aloof boy, Timmy, had exceptional intelligence and was placed in the gifted class in the public school. He made no attempts to make friends, ignored his houseparents, and showed no signs of wanting any type of relationship. The houseparents complained that they could not reach him. Timmy, a rather large boy, became prey to the smaller boys who were nonhospital children. When differences arose between them, they taunted him with being "crazy" and said he should return to the "looney bin." He reacted by "roughing up" the smaller boys.

After a rather rocky first several weeks, these three boys—Bill, Tom, and Timmy—finally achieved acceptance from their cottage groups. They were able to fit into the program and went on to gain much from it as well as from the community resources utilized by the institution.

Johnny, who came later, had an easier adjustment. Being the biggest boy in the cottage, he quickly established himself as a dominant figure there. He could not really be called a leader because of his inability to establish a group of followers, but he remained unchallenged and generally got along well with the other boys. He enthusiastically entered into the institution's program and was active in extracurricular activities in high school where he was well thought of by the faculty. His relationship with his cottage parents remained good, and he often assumed a protective attitude toward his cottage mother. Johnny eventually left the institution to enter the Army, where he has adjusted well.

The first girl who came to us was very fearful of leaving the hospital. She made a number of preplacement visits before she decided to stay.

Nine-year-old Gerry's diagnosis was schizophrenia, childhood type. Traumatic background, rejection, and inconsistent relationships had caused withdrawal from reality. Foster home placements and hospitalization were considered by Gerry to be further evidence of parental rejection. However, the fact that she was readily accepted by the children in the younger girls' cottage as well as by the houseparents helped Gerry in her adjustment to yet another placement—at our agency.

Gerry made a great deal of progress during the 2 years she was with us. At the beginning she often complained that no one liked her. This complaint gradually disappeared. She developed some close friendships, and was well liked by her peers and cottage parents. She became active in the Girl Scouts and did well in school. She was a much better adjusted child when she left the institution than the depressed little girl she had been when we first knew her. Gerry is now living happily in a foster home.

Gerry was in a cottage with younger girls who were eager to accept newcomers to their group. A different attitude prevails in the older girls' cottage where the girls form a closely knit group. There a new girl may be regarded with a certain amount of suspicion. If she is attractive, outgoing, and liked by the boys, she may be considered a threat to her peers, and her initial adjustment period may be made difficult by a lack of acceptance. An older girl must prove herself to the other girls in her cottage before she gains full acceptance from them.

The adjustment seems to be much easier for the girl who comes into a cottage where there are other girls who were in the hospital when she was. They sometimes help to pave the way for her.

Mary, a vivacious 17-year-old, came to the institution after having been discharged from the hospital to a foster home. She had been unable to accept the foster home placement, but did not require any further hospital care. She was able to accept readily the somewhat less personal atmosphere of group living and has maintained her enthusiasm. Although she has no close friends, she is well liked by the cottage parents and by the group in general. She is not pretty and has little interest in boys, so poses no threat to the girls. When she finishes high school she plans to enter a school for practical nurses.

Our Failures

Sally, a pretty 15-year-old, was an immature girl who was very much afraid of new experiences. She lacked the social skills that one might normally expect of a girl of her age. Her only recourse in disagreements with anyone was to strike out physically at the "offender." She was unable to relate to anyone and was a chronic runaway. After 2 months it was decided that Sally was still in need of the close confines of the hospital and she was returned there.

Two adolescent boys, Alan and Jack, had made marked progress at the hospital, where they had both adjusted easily. A satisfactory adjustment to our agency was anticipated. However, neither boy was able to cope with the freedom and openness of our institution.

Alan would hide under his bed and become almost rigid when he thought he was going to face an unpleasant situation. He would aggravate the other children, and when they fought back, would burst into tears. He refused to eat and would not relate to anyone. He was returned to the hospital after only 3 weeks with us.

Jack would not follow regulations. His houseparents often sought help in learning how to deal with him. When pressures became too great, he would run away and often would get into difficulty with the law. He stole from mailboxes and church boxes, broke into barns, and killed chickens. After 2 months, Jack, too, was returned to the hospital.

Another boy, Dan, had to be returned to the hospital largely because of his rejection by some members of his cottage group who had been in the hospital themselves. In the hospital Dan had been suspected of being involved in homosexual activities. Three boys who had known him there protested his coming to The House of the Good Shepherd, saying that he would cause trouble and hurt their reputations. Their influence was so strong that the cottage group rejected Dan from the beginning of his stay. When after 5 months it was clear that his emotional problems were still not resolved, he was returned to the hospital. However, in staff evaluation of Dan, the opinion was expressed that he might have been helped to work out his basic problems if his peers had not so completely rejected him.

Treatment and Resources

Casework is an intrinsic part of our treatment of every child. At intake each child is assigned to a worker who has responsibility for his treatment until he leaves. Most of the hospital children seem to build a treatment relationship quickly and to accept being transferred from the hospital worker to the agency worker as a normal course of events. They tend to ask to see their worker frequently during their adjustment period—more frequently than the nonhospital child who may never have had a caseworker before.

Johnny used the casework interviews primarily to two advantages: (1) help in making plans for weekend visits to his home, vacation planning, and, eventually, deciding whether to continue his education or to enter the Army; and (2) finding in the caseworker an adult male figure with whom he could easily identify. On several occasions he asked to see the worker to "talk things over" when he had had difficulties with his cottage parents or with boys in the cottage. With Johnny the caseworker's role was largely supportive.

The worker's role with Gerry was quite different.

The worker set treatment goals and was directive in her approach. At the same time she maintained a supportive role. Gerry was helped to establish a more healthy self-image and to accept her parents' limitations. She became more outgoing and was much more secure in expressing and asserting herself. She became interested in her personal appearance, which greatly improved.

Gerry's mother continued her habit of making empty promises, but the child reached the point where she could talk out rather than act out her hostilities. One of her most notable changes was in her ability to show affection. In the early weeks of her stay with us, she had shunned physical contact, but gradually she spontaneously sought physical affection.

The forlorn little girl who suffered frequent bouts of depression and whose main mode of coping with unpleasant situations was to run away was helped through casework treatment to face her problems in a more realistic way.

The caseworkers' roles and techniques vary with individual hospital children as they do with our nonhospital children. As with all our cases, psychiatric consultation and interagency conferences are called upon when needed.

The caseworkers played important roles in working with the five children who were returned to the hospital, helping them to accept the fact that they were not yet ready to return to communiy life, and to face their return to the hospital without feelings of failure and defeat.

There is a classroom on the institution's grounds for youngsters who are unable to tolerate a regular school situation, but as soon as feasible these youngsters are transferred to public schools in the community. None of the hospital children who remained with us needed to go to school on the grounds. Many of them entered into the various extracurricular activities of the school system as well as those sponsored by churches, Scouts, Y's, and Boys' Clubs, including summer camps.

Our own recreation program includes interagency activities as well as intra-agency functions and activities. Teams from other agencies, including the children's unit of the hospital, have played at our gym, and our teams have played return games. This has given our nonhospital children an opportunity to see the hospital setting and to mingle with the hospitalized children and so has led to some rather interesting discussions among the children about the merits of the two agencies.

Some Conclusions

Of the 12 hospital children with whom we have worked successfully during the past 4 years, only 3 are still with us. The others have left to go into the community after varying lengths of time—some after only 1 year. The average length of stay for all our children is 2½ years.

Those who have left our agency are making satisfactory adjustments to the settings in which they now are. One boy is in military service, one boy graduated from trade school and has found rewarding employment near his home, one girl is in nurses' training, another girl is about to enter a school for practical nurses, another is employed at a local hospital, and the other youngsters are in foster homes or their own homes and attending school.

Several new referrals from the hospital are now in our intake process. We do not think that ours is a "halfway" program, nor has our institution become filled with hospital children. Actually we have been quite selective in accepting youngsters from the hospital.

The diagnoses of the first 17 children received from the hospital included 13 of primary behavior disorder; 2 of schizophrenia, childhood type; 1 of psychosis due to drug reaction; and 1, manic-depressive, depressed type. The five children who had to be returned to the hospital all had diagnoses of primary behavior disorder. We do not accept or reject a child from the hospital on the basis of diagnosis, but rather on the degree of improvement shown at the time of referral and on the prognosis indicated.

As with all our children, the child from the hospital must be willing to stay, and he must participate in the agency's total program. He must have some insight into the fact that extreme behavior may be detrimental to himself as well as to the group. He must have enough ego strength to control impulses that might damage individuals or property.

Each child comes with his own individual problems, and the effect of these problems on the child's personality affects his adjustment to the setting. In retrospect, we have noted that the first three children who came to us had a relatively more difficult time adjusting than did most of those who came later. How much of the difficulty they encountered was due to their own problems and how much to our agency's insecurity in this new phase of our work cannot be clearly defined.

We have found that the children in residence judge each hospital child on his own individual merits, as every new child is judged. There has been no formation of a peer group on the part of hospital children. Each child who has stayed has adjusted to the particular group in which he finds himself. These same factors have held true in the public schools—the children have been accepted on their own merits by faculty and schoolmates alike.

Except for Dan, who was ostracized by other children from the hospital, there has been no ostracizing of hospital children by the others. The occasional taunts of "crazy," "off your rocker," and the like are not confined to children from the hospital and bring normal reactions to such name calling.

The terms "hospital child" and "nonhospital child" have been used in this article purely for purposes of clarification. No child is so identified within our agency. The children from the hospital have required no special treatment or care. Casework and other services are provided all our children on an individualized basis.

Some children hospitalized for mental or emotional illness are still unprepared for life in the community after they have attained maximum benefit from their hospitalization. A transitional period in an open type group care setting such as ours may in some cases eliminate the necessity for prolonged hospitalization. It also may cut down on hospital readmissions by helping these youngsters to develop further their ego strengths to the point where they are capable of achieving a satisfactory and enduring adjustment to daily living in the community.

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[1] Bender, Lauretta: Address to the Association of Children's Institutions of New York State. New York. 1960. (Unpublished.)

A children's unit in a mental hospital experiments with . . .

THE THERAPEUTIC USE OF STUDENT VOLUNTEERS

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ONE of the vital questions being discussed in almost every service field today is whether the scope of services can be extended by the use of semitrained persons under the supervision of highly trained professionals.[1] As yet, however, there has been little experience in the planned use of individual volunteer-patient relationships to bring about therapeutic change in mentally ill children.[2] One such program was, however, operated in Massachusetts for 4 years (1959–63), and has been discontinued only temporarily because of the difficulty of finding a supervisor. The volunteers were college students from Radcliffe and Harvard who were members of Harvard's Phillips Brooks House; the setting, the Massachusetts State Hospital at Waltham. Two years of experience with this program as its first supervisor has convinced the writer of its value both to the child patients and to the young volunteers involved.

The program actually had its beginnings as far back as 1954, when members of Phillips Brooks House organized a mental hospital volunteer program through which 200 students participated in recreational and social activities with adult patients on both a group and an individual basis and in group activities for children. In 1959, when a grant from the National Institutes of Health was received by the Harvard University Study of Student Volunteers for a demonstration and research project (Public Health Service Grant No. O. M. 233), the first "case-aide group" for individual work with children was initiated at the hospital.

This first volunteer case-aide group for children was set up on an experimental basis with five students—two boys and three girls—assigned to work individually with a single child. The children were chosen by the staff on the basis of the following criteria: They had not been selected by professional therapists for treatment; they would be in the hospital during the coming year; and they did not have severe behavior problems.

Previously, in spite of the persistent requests of the students, the professional staff of the children's unit had been reluctant to have students work on an intensive individual basis with child patients. Some staff members expressed the fear that young nonprofessionals would get over-involved in a nontherapeutic way. Some members were afraid that the volunteers, wishing to give, would be too permissive and that therefore they would have difficulty in setting the limits on behavior which are needed by disturbed children.

Because of this reluctance, the experiment was introduced only after considerable staff discussion and not until cooperation from the majority of the staff was assured. The keys to acceptance were systematic communication with staff members, from attendants to clinical director; the volunteers' demonstration of responsible performance and maturity; and the promise of careful supervision by the program's leader, a professional social worker.[3] By the beginning of the second year the program seemed to be well accepted in the unit.

Evolution of the Volunteer's Role

The students spent one afternoon a week with the children, meeting with the supervisor for 15 minutes ahead of time to be briefed on any progress or problems which the children had exhibited since their last visit. They also met with the supervisor an hour and a half afterward to discuss their experiences, the meaning of children's behavior, the norms of child development, and the concepts of mental health. Their role with the children evolved as a natural outgrowth of their experiences with their patients, plus some of the supervisor's ideas of what contributions these young adults with relatively healthy egos, strong motivation, and dedication could make to the children.

In the entire course of the students' work with the children, emphasis was placed on the value of a well-chosen activity in helping to give the children a satisfactory experience in mastery, as well as in building student-patient relationships. Activities ranged from model building, frog hunting, bike riding, shopping, reading, even shoelace tying, to walks and more walks to the local pond, park, sandwich shop, or even to a restaurant or a museum. Each activity was planned for the need of the particular patient.

The students first thought of themselves as socializing influences, bringing the outside world to children from severely deprived backgrounds and bringing the children out into the world. They also saw one of their major functions as providing individualized activities for patients who were unable to fit into organized hospital groups.

As the program continued, however, the students tried to define the exact nature of their role. Were they friend, uncle, big brother or sister, or parent to the patient? After the program had been going for a while, some professional staff members referred to the students as "therapists." This created much consternation among the students and some searching reevaluation of their function. As a monograph written by several of the students indicated,[4] the volunteers found it easier to assume the socially validated role of big brother or sister than a more parental or professional role.

Near the end of the first year, the students redefined their role in a report presented at a hospital staff meeting. They said they would still maintain the important function of the volunteer in representing the outside world as a friendly place to the patient; but that they felt having a relationship in depth with each child had even greater value. With the supervisor's help they defined the case-aide role as ego-supportive, educative in the broadest sense of the word, and parental in that it brought the child healthy relationships and activities that are a part of the normal experiences of childhood.

Clarifying Goals

At the beginning of the first year, both students and supervisor had very limited goals. We did not hope for fundamental changes in the patient's total functioning. We hoped only to support and to strengthen the intact areas of the patient's personality which enabled him to function to some extent. Only a few months after the program was initiated, however, two of the children who had been most deprived of steady adult support, and who had been unable to trust adults, began to show striking changes in ability to relate to people—at first with their volunteers and then with other adults in the hospital. Goals of the students and supervisor gradually became more ambitious and clear.

For example, two statements on goals written by one student, Ellie, at different times of the year showed maturation on both her own and her patient's part. The patient was a 9-year-old boy who had been admitted to the hospital after uncontrolled attacks on children and animals. He had been diagnosed as borderline psychotic with possible organic brain damage. In the hospital his behavior had been withdrawn and babyish, a "too good" reversal of his former aggressive behavior.

In October after first seeing this young patient, Ellie wrote:

> I want to give Billy a true friend. I hope to give Billy self-confidence to help himself to the extent that he doesn't feel he must seek attention or love by asking people to do things for him that he can really do for himself.

In May, Ellie described her role and goals in different terms:

> I wanted him to be able to use me as an example of a stable, loving, female figure which he had never known, to use his experience with me in his relationships in the future. . . . I wanted him to feel that he could talk to me or express himself in actions without evoking harsh judgments or retaliation, whatever he did. It is only by expressing his feelings in words,

> as he is beginning to do, that he will learn inner controls and only in this way will he gain confidence in himself, other people, and his ability to sustain meaningful relationships.

She added: "In the last 3 months I have had success," and she had indeed. Her patient's new maturity and confidence were noted by members of the hospital staff. He was talking more and holding his own with his more aggressive peers. In his relationship with his volunteer, he was able, at last, to express his own ideas in choosing activities and to tell her some of his fears of aggression and retaliation. Billy's progress was so apparent that the decision was made to discharge him at the end of the year.

In the first 2 years of the program 12 college students took part in this volunteer case-aide program. Their general goals fell into the following seven categories. (The examples give an indication of their plans and accomplishments.)

1. *Teaching that loving people is not dangerous.* The forming of relationships with parental figures in the early weeks and months of life plays an overwhelmingly important role in ego development.[5] Many of our child patients had suffered pathogenic experiences with significant adults due to illness, accident, or their parents' lack of capacity to furnish love. Because of early disappointments, reinforced in many instances by later separations, the children were fearful of placing trust in people or of investing emotionally in the experience of loving others.

Richard, an 8-year-old boy, was diagnosed as psychotic. He showed little emotion or feeling even on separation from his parents. Much of his day was spent in fantasies of space and rockets. He identified himself with the most powerful objects and said he "liked nothing in this world."

Early in the year, Nancy, the student who worked with Richard, said she hoped—

> to form a relationship that would have meaning for both of us and to use it to help him decide to want to live in this world.

In describing her relationship with him at the end of the year, she said:

> We love each other. Our relationship is a blend of mother-child; friends; older sister and younger brother. The best way to describe it is to say he is my child and I am his volunteer. In the beginning he seemed not to know how to understand and accept love. Now human emotions and feeling have real meaning for him. He can express and receive affection.

The ward psychiatrist noted the enthusiasm with which Richard waited for the coming of his volunteer. She also noted that at the end of the year he was showing a response to other adults and even a sense of humor. He said to his volunteer, "I have got 'real' feelings, you know." It was true.

Lewis, age 10, had been diagnosed by the staff as having a "schizophrenic reaction." His mother, who was both educationally and emotionally deprived, had been deserted by his father. She had turned to Lewis to fulfill her emotional needs and was overtly seductive with him. At the same time she was terrified of his attempts to seem grown up.

Lewis was always confused about whether he was a little boy or a grown man. He began to show signs of great emotional disorganization about the time he entered school. He was hallucinating and had a rich fantasy life with delusions of destructive nature. He also showed paranoid traits and seemed unable to form relationships. However, his outward appearance was deceptively one of maturity, adequacy, and independence.

Ruth, his volunteer case aide, described her goals with Lewis:

> My primary aim was to provide Lewis with a nonseductive relationship with a female. When I realized that he had problems about dependence, denying his need for it and trying to control the relationship, I tried to encourage him to share control with me and to rely on me for some things. . . . I wanted him to feel he could trust me.

At the end of the year, she said:

> I found with all the goals I set I was able to help Lewis accomplish some things. . . . I felt I was able to give Lewis a chance to see some of the facets of possible healthy human relationships and experience them with me. . . .

Ruth was able to have a nonsexualized relationship with this child, a pal relationship which he had not achieved with any other adult. She used his interest in scientific matters, closely allied with his previous exclusive interest in human anatomy, as a means of finding a socially acceptable sublimated outlet. The two worked on nature projects associated with insect life, went on several frog hunting expeditions, and built puppets together. At relaxed moments, Lewis, a virtual nonreader, could even read a bit with Ruth.

2. *Helping patients achieve a sense of self-identity and self-esteem.* Peggy, a student volunteer, set as one of her prime goals with Mike, her patient, the hope that she could help him feel valuable and important to someone. Mike was a child twice rejected: first, by his natural parents; then, by his

adoptive parents. He was of illegitimate birth and mixed Oriental and Caucasian ancestry. Mike had been accused of aggressive assaults and fire-setting by his adoptive parents. However, he did not misbehave at the hospital, where he was observed to be a basically depressed child with a placid exterior. He refused to relate to anyone more than superficially.

Peggy, a warm and perceptive girl with much experience with children, said, "I felt he was worth while. I tried to show him this so he would believe in himself again." Mike responded rapidly to Peggy and began to respond to other adults in the hospital as well as to show improvement in all his functioning. After 9 months the hospital staff, which had despaired of placing him outside the hospital, decided to place him in a foster home, where he has adjusted successfully.

Chris, another student, tried to formulate realistic goals with 11-year-old Georgie, who was said in staff conference to be "in and out of psychosis." Known as "Fatso" on the ward, Georgie was described by the staff consulting psychiatrist as an "empty container with a façade of secondary identification." Chris wished to give him a firmer sense of self-identity, a greater feeling of self-sufficiency: "He must learn what sort of person he is and have a greater sense of being a real, whole person."

Toward the end of the year Chris took Georgie on a visit to the local zoo. While there Georgie talked about what it would be like to be the various birds and animals he saw, but finally sighed, "It's always better to be yourself."

3. ***Providing auxiliary ego and superego in times of stress.*** One important function of the student volunteer case aides is to lend the support of a healthy ego to the child and to serve as his superego, thereby helping the child achieve a more accurate perception of reality.

Peggy's second patient was Hilda, an adolescent girl of 14 who was mute and withdrawn in her first weeks at the hospital. At first she was thought to be schizophrenic, but psychological tests and her subsequent behavior indicated that she had probably been in a depressive reaction precipitated by the hospitalization of a psychotic older sister. Hilda's depression gradually lifted, aided, perhaps, by the attempts of Peggy and the ward personnel to entice her into enjoyable activity.

Soon, however, Hilda began to make aggressive sexual overtures to the younger boys in the hospital and to engage in other delinquencies. Through these crises, Peggy attempted to give her young charge the feeling of self-esteem, at the same time indicating strong disapproval of her asocial acts. The ward personnel spoke of Peggy as the one person close enough to Hilda to be able to stand by her during her difficulties and not to feel irritated by her misbehavior and her many demands. At the end of the year, Hilda, although somewhat flighty and overtalkative, at times seemed aware of her problems, aware of the world, and anxious to find her place in it.

4. ***Providing corrective emotional experiences with an adult.*** We should never minimize the importance of identification with the healthy characteristics of an adult as a mechanism providing tremendous impetus for growth in young children, particularly children who have had faulty models in their early lives. The students' youth and their deep emotional commitment to the children assigned to them made identification with the volunteer a striking feature of most of these volunteer-child relationships.

We have already referred to Nancy's loving and truly selfless relationship with Richard. After many months of experiencing this, Richard began to show some concern for Nancy's feelings. When he kept her waiting, he said, "I'm sorry to do that to you." In the last several meetings, he began to show awareness, interest, and loving concern for other children whom he previously had ignored. The gentle words he used to express his concern for the wishes of these children were duplicates of phrases he often heard from his volunteer.

Georgie, who had learning difficulties, pointed proudly to the Harvard shirt Chris had given him and said, "I'll wear this to my test tomorrow. I'm a Harvard. I'm Chris." A happy sequel was that he passed his test with room to spare and graduated to the next grade.

Mike, on leaving the hospital, said to his volunteer, "I'm going to take you away with me here," pointing to the area of his small middle. How many professionals can claim such a testimonial from a satisfied client?

5. ***Helping to establish inner controls.*** The controls of disturbed children are always poor. Necessary for almost all our children was the setting of firm limits to aggressive behavior and to emotional and material demands. We hoped that the children would incorporate some of these outside controls and make them a solid part of their functioning. In

testing how far they could go with the volunteers, the children often seemed to be asking, "Can you control me as well as love me?"

One of the volunteers learned dramatically that her patient was much happier when she imposed limits on his acting-out behavior. Once she allowed him to attack her physically, and so much anxiety was aroused in both that it was evident in their relationship for many weeks. Both volunteer and supervisor had to work hard on ways of handling this.

6. *Teaching that there may be ways to handle old problems.* The children could also be taught new methods of securing some of the emotional rewards of love and attention, status and achievement. Billy learned from his volunteer that achievement in doing things for himself, even tying a bow, brought more positive attention than did helpless babyishness. Georgie learned new ways to approach the "kids" on the ward. Chris, his volunteer, accompanied him in spirit through his tortuous odyssey from ward scapegoat, through placation and identification with aggressors to, at last, holding his own as a member of ward society. Georgie's social worker said with surprise, "Georgie just stopped being the ward pushover."

The students also tried to redirect some of the children's socially unacceptable expression of impulses into more acceptable channels. Many of the planned activities, from bowling for Billy, who feared his own and others' aggression, to science projects for Lewis, had sublimating aims.

7. *Strengthening healthy aspects of the patient's functioning.* The students encouraged those of their patients' interests and modes of functioning that were clearly healthy. Hilda had some real intellectual ability and loved to read. Peggy used this to interest her in serious reading projects. She also encouraged her to write.

Chris used Georgie's interest in animals and nature to teach him about some aspects of human relationships. Ruth drew on Lewis's executive ability in helping him carry on a puppet project designed to win him respect from his peers.

Unique Contributions

Students and supervisor tried to factor out together the elements that made the case-aide contribution to the children different from the contribution of the professionally trained therapist and of the semitrained, paid attendant counselor, often also a student with background courses in psychology and sociology. They identified the following unique elements in the volunteer-patient relationship:

A student volunteer serves as an adviser to a mental hospital patient who has written an article for the hospital newspaper.

1. *The patient looked on the volunteer as a representative of the community outside the hospital.* The case-aide volunteers of the children's unit took the children off the hospital grounds as often as possible, trying to give them the kind of experience available to normal children. Usually they spoke with pride of their patient's good behavior in restaurants and museums, behavior which often was exactly opposite the child's usual behavior in the hospital. Moreover, in taking the children into the community they had an opportunity to witness many of the difficulties the children had in dealing with the world outside the hospital—from unrealistic fears to not knowing how to behave in various situations. Such difficulties were handled on the spot by the students, often with therapeutic results.

2. *The case-aide relationship was activity oriented.* The activities not only had great ego building values in themselves, but also provided an easier way for children who had much difficulty in verbalization to build a relationship. For some of the children in the hospital, the relationship with the volunteer case aide provided the impetus for giving up a deep distrust of adults. Through the case-aide program, which was less threatening to the children than the traditional forms of therapy, once unreachable children developed the ability to relate meaningfully to

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adults and so became receptive to other forms of psychological help.

3. *The volunteers' youth made them highly suitable as figures for identification.* In two cases of preadolescent boys, identification with male volunteers was especially marked. Both these boys had undergone several years of psychotherapy but neither had matured so rapidly and noticeably as he did in the 9 months of "case-aide therapy." One boy who had been in the hospital for 3 years was ready for discharge at the end of the year. The other was allowed to go home for an extended visit for the first time in several years.

Some of the successes that college students have had in working with emotionally disturbed children may also be related to the fact that college students have just resolved or are in the process of resolving many basic issues of maturation. In late adolescence identity problems, particularly those associated with sexual role and career choice, are among the most pressing issues besetting the individual, and their successful resolution spells the difference between a productive and an unfruitful adult role. Since the emotionally disturbed child is also grappling with many problems of identity, though on a different level, the college student is in a position to be particularly sensitive to many of his struggles and needs. In many cases the supervisor observed that as the student aided the child in working out the problems of self and maturity, the student too seemed to be achieving a definitive solution for himself.

The role of the supervisor required much thought and continuous reappraisal.[3] The goal was always to retain the volunteer's asset of nonprofessional spontaneity and, at the same time, to sensitize him to the meaning of the patient's behavior and to ways of handling it. The professional always had to assume responsibility for judging and balancing the interests of patients, volunteers, and hospital program.

In noting the progress of the patients who were involved in this program some other factors besides the volunteers' services must be kept in mind—especially improvements which were taking place in the hospital milieu, the ratio of staff to patients, and general staff morale. Nevertheless, assessment of the program has to rely on the clinical judgment of the hospital staff, who can note changes in behavior and symptomatology. After the first year of the program, the ward psychiatrists, who have the greatest formal responsibility for the total planning for the patient, reported that three out of four children in the program the entire year showed improvement in functioning. In the second year, when patient selection had the advantage of some experience, the ward physicians reported change and progress in all seven patients. In several cases psychological tests confirmed positive growth. At the end of the first year, two of the five patients were discharged. At the end of the second year, two of the seven patients were ready for discharge, and a third had gone home on extended leave.

The experience of this program indicated that college student volunteers have much to offer in the therapeutic armamentarium of a State hospital for children. Students, supervisor, hospital staff, and patients, by their own statements, were united in this belief.

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[1] Eliasoph, Eugene: The use of case aides in a treatment setting. *Social Casework,* March 1959.

[2] Joint Commission on Mental Illness and Health: Action for mental health. Basic Books, New York. 1961.

[3] Reinherz, Helen: Group leadership of student volunteers in a mental hospital. *Mental Hospitals,* November 1962.

[4] Umbarger, Carter et al.: College students in a mental hospital. Grune and Stratton, New York. 1962.

[5] Gerard, Margaret Wilson: The emotionally disturbed child. Child Welfare League of America, New York. 1957.

> . . . there is nothing so good for a nation as to become interested in doing good work.
>
> "The War on Poverty," *Walter Lippmann, in the* Washington Post, *March 19, 1964.*

A mental health clinic experiments with . . .

JOB-FOCUSED TREATMENT FOR ANTISOCIAL YOUTH

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A MAJOR CONCERN of practitioners attempting to offer appropriate service to antisocial adolescent boys has been the development of effective ways to attract them to participation in a meaningful treatment program. Methods have varied from traditional psychiatric and casework approaches to experiments in paying youngsters to appear at the clinic. The characteristic resistance of antisocial adolescents to almost all efforts to involve them in treatment has resulted in their clinical reputation as a most difficult group to reach.

The technique reported here was developed as a method for reaching and treating antisocial adolescent boys who were no longer attending school. Since 95 percent of all 17-year-old delinquents, 85 percent of the 16-year-olds, and 50 percent of the 15-year-olds are not in school, this program has pertinence for a substantial number of young people.[1, 2]

The technique was based on observations regarding the treatment needs of such adolescents which have been repeatedly noted by many mental health workers [3, 4] and provide the underlying structure for some of the newer programs of intervention. These observations point up:

1. The need for individual psychotherapy, focusing on problems of personal adjustment to home and community.
2. The need for remedial education for most of these young people, who often lack basic educational skills and who function far below grade level.
3. The need for vocational assistance, with job placement a major objective.

While it is generally agreed that seriously disturbed, antisocial adolescents need psychological, educational, and vocational help, they often reject such assistance when it is offered by isolated specialized professionals in a way which seems unrelated to the circumstances of their everyday existence. Even a modern mental health clinic which utilizes a collaborative team approach involving psychiatrists, psychologists, remedial educators, and social workers encounters problems in reaching these adolescents. An hour of psychotherapy with one professional followed by an hour of remedial education with another often fails to meet the antisocial youth's immediate needs. The practical service of direct job placement, more readily acceptable to the adolescent, also ends in failure when he is not prepared for entrance into the working world nor given adequate support once employed.

Troubled young people referred to mental health clinics tend to regard psychotherapy as "head shrinking." The threat of a dependent relationship represents to them an intolerable admission of weakness. They also reject education in the rigid, school oriented form as unrelated to their needs and a source of frustration and failure.

Few therapeutically oriented clinics offer any regular vocational counseling. When such help is made available through the clinic, this is apt to be in a haphazard way with little concern for the dynamic role employment might have for an individual adolescent. Other placement services available to school dropouts do not offer the integrated psychological and educational help that dropouts with antisocial tendencies must receive if the vocational assistance is to be effective.

Plan of the Project

The approach described here traces its origin to a pilot project carried out from 1957 through 1961 by the Judge Baker Guidance Center in the public schools of Newton, Mass., a large middle income suburb of Boston. Supported by the National Institute of Mental Health, the project was designed to explore new methods for treating antisocial youngsters from such an area who presented serious acting out problems in the school and community. As a result of the knowledge gained from this effort, the center's staff decided that special techniques were necessary for the treatment of adolescents with gross learning and behavioral problems which were not generated from disorganized social conditions. To test out some specific aspects of these techniques, the United Community Services of Boston made funds available to the Judge Baker Guidance Center during 1961 and 1962 for the investigation reported here.

The young people involved in this comprehensive therapeutic effort were selected through the cooperation of the Newton public schools. The supervisor of attendance referred adolescent male dropouts who had had a stormy record to the investigator *as soon as they had left school.* Not all dropouts were referred; only those who had a history of repeated truancy, long standing problems of poor school behavior and academic performance, and a court record as an adjudicated delinquent. The school had either suspended the boy or he had dropped out because such suspension was imminent. Every such dropout over 15 years of age who left school during the fall of 1961 was referred until the total caseload of 10 was attained. The boy had to be over 15 so that he would be eligible for full-time employment in Massachusetts.

The comprehensive, vocationally oriented treatment program presented here involved vocational assistance, remedial education, and intensive psychotherapy. These techniques were utilized in a flexible, combined approach and were offered by *a single practitioner* with job placement as a matrix for other therapeutic efforts. The practitioner had been trained in counseling and guidance in a psychoanalytic setting.

Employment, which is therapeutic in itself, was used to provide a focus in reality for the psychotherapeutic and re-educative endeavors. For antisocial adolescents, work can play a crucial role not only because it facilitates identity formation, provides an avenue for the channeling of aggressive and sexual energies, and alleviates material needs but also because it can be used as a fulcrum for therapeutic intervention. The practicality of employment serves as a motivating experience for treatment and provides a testing ground for newly acquired insights and skills. Fortunately, Newton had many employment opportunities for adolescents.

Unlike most clinic programs, this service did not have a central base of operation. Moreover, it was made clear to the boy that the service was independent of the school and court. The therapist contacted the boy either by telephoning him or by leaving messages at local places which he was known to frequent and offered him help in finding a job. He was told that the therapist would meet him anywhere in the community to discuss the service, and that he could select the time and place. There were few time restrictions on contact or activities, and the therapist varied his techniques with the demands of the immediate situation. Sometimes the boys were seen as many as 8 or 10 times a week. This kind of flexibility was maintained in all phases of the program. The self-initiating, individualized aspects of the service were stressed as well as the boy's personal responsibility for making decisions.

Dropping out of school represented a crisis point to the youths involved and made intervention possible. Since they came from a suburb where gang structures were relatively loose, they were not able to find new gratifications in organized gang activities and so were more amenable to help. Without exception, each boy when offered the service within a day after leaving school expressed interest in exploring the possibility of getting a job.

The offer of help in getting a job was the only method used to attract the boy to the service. The availability of other types of assistance such as educational planning or help with personal problems was merely mentioned during the initial contact as a future possibility. No part of the program was compulsory. The boy made his own decisions.

A Comprehensive Approach

Once the youngster agreed to try the program attention was focused on preparation for a job. The boy was always anxious about this venture, although his overt attitude frequently suggested overconfidence and even belligerence.

Early in the interaction between boy and therapist the flexible qualities of the relationship were brought to the boy's awareness. For example, to get a job in a gas station the boy usually needed a driver's license. If he did not have one, the therapist offered to help him study the driving manual and acquire a license. Thus, by being willing and able to provide the kind of aid the boy needed when he wanted it, the therapist solidified the relationship and illustrated the usefulness of the contact. The related remedial activities were rooted in a practical need which tended to make them acceptable to the boy.

A general empasis on concrete action throughout the therapeutic program was its most distinguishing characteristic.

Another feature of the method, distinguishing it from many vocational counseling approaches, is that it relied on no preselected list of jobs or employment agency. Each potential position was selected with the youngster on the basis of his individual interests, aptitudes, and needs. The therapist's knowledge of the community and its resources, gained from close contact with school and community personnel, served as a source of information about job possibilities. Although the suburb in which the study took place offered many opportunities for employment (thus differing from some areas with chronic unemployment problems and limited job opportunities), it was clear that these boys, because of their personality difficulties and their limited skills, could not by themselves take advantage of the opportunities available. The therapist, therefore, went with each boy to various employers to inquire about positions. Thus the boy experienced the process of job hunting with its many frustrations, an important part of the therapeutic process.

When the boy finally secured employment, his situation on the job provided a new focus for the continued exploration of his personal problems. Difficulties he encountered were examined and used as the avenue for communicating psychotherapeutic insights. Academic inadequacies exposed while working were met by an individually tailored program of remedial education. When the boy saw that the educational activities were necessary for the improvement of his skills on the job, he was willing to try them.

In no case were difficulties encountered in keeping the boy in therapy after he had obtained a job. This may be explained in part by the fact that because of the concrete emphasis the boys did not regard the service as psychotherapy. The therapist held interviews with the boy at least once a week, but these were informal and varied in time, place, and focus. The boy even occasionally was visited on the job. He was encouraged to contact the therapist if at any time he felt a need to discuss anything. Finally, when he felt able to keep a regular schedule with the therapist a specific interview time was established.

Eventually the boy realized that the therapist could be of assistance to him in many areas. In such an atmosphere of growing trust and acceptance he was willing to consider the distortions and contradictions in his perception of reality and to discuss various alternative solutions to his problems. In this way it became possible to begin the intensive psychotherapeutic work which would have been rejected at an earlier stage.

An Example

An example of the use of this comprehensive approach can be seen in the case of a 17-year-old boy, Jerry, who had been expelled from school after a long history of difficulty and antisocial behavior. Jerry was well known in the community for his misbehavior, ranging from street fighting to car theft.

> The therapist first reached Jerry by telephone and told him that individual help was available to boys who left school early in their efforts to find work. In the first interview the boy's ideas about work were explored. When Jerry said he was interested in becoming an auto mechanic, the therapist inquired into his concept of this job—what the nature of the work was, the training necessary, the pay, and future opportunity. Jerry did not know the answers to these questions so he and the therapist found them together. They took several trips to automotive and auto body shops and then discussed their first-hand observations of this occupation.
>
> Jerry's distortions and denials, such as his insistence that he left school because "the work wasn't hard enough," were directly examined. The therapist was constantly on the side of reality, and Jerry began to realize that contradictions in his statements would be noted and pointed out. Finally a job possibility was selected and Jerry went for an interview. This was not for a job as a mechanic—a grossly unrealistic expectation for Jerry at this time—but for a job as a general helper at pay far below his earlier expectation of $2.50 an hour.

Much work had gone into preparing Jerry for the day he would have his first job appointment. Practice at filling out forms and meeting a potential boss had been extensive, with the therapist playing various employer roles. Two months were spent practicing driving the therapist's car and studying the driver's manual so that Jerry could get the needed driver's license. When Jerry said that the manual was too difficult, a fact the therapist anticipated because of the boy's trouble with employment applications, the therapist taped the contents and lent him a recording machine. Getting a license served as an opening to discuss needed academic pursuits. It also provided the therapist with a glimpse of Jerry's problems in controlling aggression and his extremely hostile attitude toward authority figures.

Jerry's interview was a success and he was hired. At work many problems arose that nearly cost him his job. Finally, when he was accused of stealing desk pads from the office, he became angry, fought with the boss, and was fired. Together Jerry and the therapist explored the possible reasons for this occurrence in an effort to gain some insight from his performance at work.

Jerry was able to express his rage and concomitant shame over what had happened on the job. His attempts to project the blame on everyone but himself were not allowed to pass unchallenged. Soon it became apparent that the core of the problem lay in Jerry's intense hatred of the boss and his attraction to the boss's secretary, a recapitulation of his feelings toward his father and his mother. This was a pattern observed in many of Jerry's other relationships. The therapist worked with him in considering his home life and the problems he had with both parents and in relating to people. Parallels were gradually drawn between some aspects of his past experience and behavior and his present mode of response. After two more job attempts the boy had achieved enough stability to maintain his position and had gained some valuable insights into the meaning behind some of his actions.

Jerry's performance on his first job had exposed his academic deficiencies, a source of great embarrassment to him. Around the sixth month of treatment a tailored remedial program was developed. At first it was solely job oriented—reading mechanics manuals, using fraction concepts in considering the use of wrenches, and trouble shooting on the therapist's car. Soon the activities became more general although always concrete in nature.

Jerry's academic deficiencies emerged clearly one day at a restaurant. Jerry always ordered the same thing when he and the therapist went out to eat. When the therapist asked about this and confronted him with a menu to read, Jerry's eyes filled with tears as he admitted that it was not possible for him to do so. The next day's tutorial work contained a period of time devoted to the reading of menus, thereafter a regularly pursued activity.

During treatment the active, flexible nature of the relationship was emphasized. In essence the therapist entered all areas of Jerry's life. Activities such as job finding, court appearances, pleasure trips, going to the dentist, shopping for clothes with a first paycheck, purchasing a secondhand car, and others required a maximum commitment on the part of the therapist.

Finally, Jerry was able to hold a job. His acting out behavior was reduced and eventually disappeared entirely. Better controls were evidenced and the boy seemed more aware of his real needs, strengths, and weaknesses. After 3 years on the job Jerry became a mechanic's assistant. He is now in a training program offered by an automotive manufacturer.

Some Results

The effectiveness of this comprehensive, vocationally oriented psychotherapy in reaching and treating adolescent antisocial youths has recently been objectively demonstrated.[5] A formal evaluation of the approach showed significant changes in the personality dimensions of self-image, control of aggression, and attitude toward authority in the treated group when compared with an untreated group matched for IQ, age, and socioeconomic level. Improvement in performance of academic tasks in the treated group was also marked. (Achievement tests in reading, vocabulary, arithmetic fundamentals, and arithmetic problems were administered.) The evaluation also indicated that the treated group had achieved a more favorable job history and showed a reduction of antisocial behavior.

In summary, the traditional roles of the psychotherapist, remedial educator, and vocational counselor were challenged in work with antisocial adolescents in a suburban area. The success of a concrete, flexible approach drawing upon the skills and knowledge of all three disciplines as they relate to these adolescents and their specific needs at a given time suggests the necessity for multidisciplined training for those interested in working with this group of young people. Moreover, the possibilities of initiating a service of this kind within the schools or community warrant serious consideration.

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[1] Wolfbein, Seymour L.: Education and employment. *In* The Nation's children; vol. 2: development and education. (Eli Ginzberg, ed.) Published for the Golden Anniversary of the White House Conference on Children and Youth by Columbia University Press, New York. 1960.

[2] U.S. Department of Labor, Bureau of Labor Standards: Young workers under 18 today and tomorrow. 1958.

[3] Patterson, C. H.: Counseling the emotionally disturbed. Harper & Bros., New York. 1958.

[4] Judge Baker Pilot Project in Juvenile Delinquency: Field demonstration and training project. (Unpublished report.) 1960.

[5] Massimo, J. L.; Shore, M. F.: The effectiveness of a comprehensive, vocationally oriented psychotherapeutic program for adolescent delinquent boys. *American Journal of Orthopsychiatry,* July 1963.

PATTERNS OF HELP FOR POST-PARTUM MOTHERS

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MOST PEOPLE recognize that mothers just home from the hospital with their new babies need assistance with household tasks and child care. Customs dictating how this should be done have varied over the centuries and among societies. There is reason to believe that families today, as always, provide help for the post-partum mother and baby, yet little factual information exists on how they do this and what kind of professional service and community resources are needed to assist them.

The shorter hospital stay currently practiced in obstetrics adds importance to knowing how families manage during this period. Early ambulation may not be synonymous with early ability to resume household duties and care of the family.[1] Also, the tendency of families today to live as a conjugal unit, separated from both pairs of grandparents, economically independent of them,[2] and often far distant from them, suggests that relatives may not be so available to give this assistance as in previous generations. Although recent publications have recognized the importance of this type of help,[3-5] no detailed description of the patterns of help has been presented nor has any analysis been made of factors which determine the pattern of help that a family uses. This study, made in one North Carolina county, represents an attempt in this direction.

Sample and Method

In order to delineate and analyze various patterns of help, an interview guide was devised to gather data on (1) the plans for help that the mother and father made before the baby's birth, (2) who provided the help, (3) what each helper did, and (4) what advantages and disadvantages the mother perceived at the end of the post-partum period in the kind of help she used. Also, information was collected on certain characteristics of each family, such as age, residence, number of living children, occupation, and education.

The sample consisted of all mothers with normal deliveries and normal infants delivered in May and June 1962 whose addresses were in Orange County, N.C. Illegitimate births were not included. Normal deliveries were those in which the mother had no serious complications of pregnancy and no coincidental disease. Mothers whose babies were born prematurely, defined as weighing less than 2,500 grams (5½ pounds), or showing gross abnormalities, were omitted.

Orange County has a population of 42,970, according to the 1960 census—71 percent of it rural. The number of cases in the study sample was 131.

The deliveries took place at the University of North Carolina Memorial Hospital, the only hospital in Orange County, and in five hospitals of the neighboring counties of Durham and Alamance—hospitals delivering 98 percent of the babies born to Orange County residents.

For this study, 28 days following delivery was designated as the post-partum period. All the mothers were interviewed in their homes 4 weeks following the birth of the baby.

Each mother was asked to designate the person she had used as a principal helper. If there had been more than one helper, the one designated as principal was the helper whom the family had planned for, who was at the home or place where the first part of the post-partum period was spent, who was helping immediately on the return of the mother from the hospital, and who performed some work within the household.

General Findings

The large majority of the couples, 111, normally had no other persons in their households except their children. Fifty-four of the mothers were primiparas; 54 had 1 or 2 living children other than the new baby; and 23 had 3 or more other children. The parents' educational achievement ranged from below high school to postgraduate university; their occupations from domestic service to professional work.

Fifty-four of the mothers said they felt fine or had no complaints other than tiredness during the post-partum period. The rest, 77, specified one or more physical complaints. Three of the mothers were re-admitted to the hospital, one when she broke her arm, one for what she called an "infection inside," and the third because of an "abscessed stitch." Another was advised to re-enter the hospital but was unable to do so. Complaints by the mothers became fewer each succeeding week of the period. Many, however, complained of tiredness at the time the principal helper left.

Most of the mothers had planned for post-partum help during their pregnancy, 60 planning during the first and second trimester and 40 during the third trimester. Ten did their planning at delivery. Twenty-one said there had been no planning or could give no definite answer.

Thirty-five of the mothers said that the idea that help would be needed originated in themselves, 8 said that it was the father's idea, 24 said they thought of it with their husbands; 31 gave a relative the credit; and 16 said it came from a professional person. The remainder, 17, could not remember where it arose.

Sixty-three of the mothers reported that they felt they had had some choice about who would help them; 20 said that "perhaps" they had had a choice; and 44 stated definitely that they had had no choice, that what was done was the only possibility in their circumstances.

The most frequent reason given for wanting help—reported by 32 mothers—was that the mothers expected to be tired and would not feel strong enough for the work that would need to be done. Others were more specific, 20 reporting they had wanted help for the older children, 17 for housework only, 16 for care of the baby and the housework, 9 for both the household and the older children, and 11 for other combinations of reasons. Twenty-six could not state their reason or had not expected to need outside help.

Principal Helpers

The principal helpers were: maternal grandmother, 45; a paid worker who was not a relative, 22; the father, 17; paternal grandmother, 15; maternal relative other than the grandmother, 15; paternal relative other than the grandmother, 7; a child in the family, 7; a friend who was not paid, 2; and no principal helper, 1.

Many families had more helpers than the principal one. Fifty-three of the mothers had 1 additional helper, 45 had 2, and 27 had 3 or more, exclusive of the husband.

The principal helpers serving 1 week or less were 35; up to 2 weeks, 28; up to 3 weeks, 20; up to 4 weeks, 12. The remainder, usually persons who were permanently part of the family, served over 28 days.

In 105 families, the plans as to who would help went according to the original plan; but in 11 of these the helpers stayed for less time than originally planned, and in 8 the helpers stayed for longer than planned. In 15 families, original plans miscarried, and in 11, plans had not been sufficiently well-formulated for the mother to say whether or not they had been carried out.

Maternal Grandmother

In 11 of the 45 families in which the maternal grandmother was the principal helper, she was the only helper with the exception of the father. In six of these families the paternal grandmother also came to the home as a helper. When both grandmothers were used, the maternal grandmother came first for a week or so and the paternal grandmother followed, staying about the same length of time.

The use of the maternal grandmother bore a significant relationship to the age of the mother, to the number of babies the mother already had had, and to the purposes for which the mother wanted help. The use of the maternal grandmother decreased by 10 percent with each 5-year increase in the age of the mother. She was used significantly more with the first and second child than with subsequent children, and she was used significantly more when the mother wanted help with both her baby and the housework. The use of the maternal grandmother as principal helper bore no significant relationship to the birthplace, educational level, or occupation of the father or mother, nor to race, place of residence of the couple (whether town or country), nor to how far away the maternal grandmother lived.

The maternal grandmother's average stay was a little less than 2 weeks. Within the household she usually helped the mother with some of the management aspects of housekeeping, such as preparing the shopping list and planning the meals. She also took some part in preparing meals and the baby's formula and helped with bathing the baby and with the baby's laundry. She was often up at night with the baby. She did not do a great deal of dishwashing, housecleaning, laundry for the family, or diaper changing.

The mothers cited many advantages in having the maternal grandmother as helper. Some spoke of her dependability; she did not need to be watched over. They could talk to her freely, ask her questions, and compare ideas with her about baby care. Her likes were similar; she cooked the same way. She was comforting: "When you are cranky, she understands better." As to the other children, "It is best to have their grandmother because they have a friend in her." However, there were some qualifications: "It depends on how your husband gets along with her." "It is easier to ask paid help to do things than your mother." "I felt I was putting too much on her."

Paid Helper

The paid helper, used in 22 families, was employed significantly more by families in which the father was engaged in professional or skilled occupations, by those in which the mothers had been working since marriage in the higher grade occupations, and by those in which both father and mother had more than a high school education. Only 8 of these 22 families were having their first baby. The mother or father or both had made the decision to have this kind of help in all but four cases.

The group of families with paid helpers contained the highest proportion of mothers who had consulted with the doctor during the post-partum period either about themselves or the baby.

All paid helpers were between the ages of 30 and 60. They had had some previous experience in domestic work; three were known in the community as persons who specialized in helping at this time. The mothers using the "specialists" were well pleased.

The paid helpers came for the day and did not remain overnight. Their average length of stay was almost 3 weeks. Thus, they tended to remain longer than the maternal grandmothers. Generally, the paid helpers did not prepare the shopping lists, do the shopping, or plan the meals. Most of them prepared the meals, washed the dishes, and washed for the family. Some washed for the baby; only a few bathed the baby. All cleaned the house.

In the mothers' views advantages in this type of help predominated over the disadvantages: "I did not have to worry about the housework." "When you have one baby needing attention and the other two also and everything happens at once, having help makes the difference between your being nervous or calm." However, this help was not always satisfactory. Complaints were: "She did not do what I expected. She wanted to be the baby's nurse and I wanted someone to do the housework." "She was a constant threat to our little boy. I think he was afraid that I was going to leave him." "She would sit down and watch TV." Four of the paid workers were dismissed.

Some of the mothers offered advice about paid help. It is important to select someone who is dependable; it is not well to start with an inexperienced maid; the helper should come in advance to become familiar with the family's ways of doing things.

The Father

While the father had been the principal helper in 17 of the families, in no family in the lower educational levels was he so used. Eight of the fathers were students. Eleven of the mothers were having their first baby. Of the 17 families, 8, all primiparas, had not expected to need much help; 7 of the other had tried to make some other plan but had been unsuccessful. In nine families the father took his vacation during the weeks after the wife returned from the hospital.

In these families the mother planned the meals and prepared the shopping list and the father did the shopping and took responsibility for the family laundry, usually taking it to the laundromat. The majority of the fathers shared with the mother the other household tasks and the care of the baby and when there were other children took more than their customary responsibility for them.

The mothers' comments in these cases often focused on the father's relationship to her and to the baby: "I liked my husband doing it. There is closeness in the beginning with the baby." "I wanted my husband to feel that the baby was his, too. With another person coming in to help, your husband may feel he is not needed any more."

An older mother said, "Everything has been perfect. We all planned this way back and we are all enjoying it. My husband took his vacation and the girls (aged 13 and 14) were on vacation from school. They were all ready. The girls help Daddy with breakfast in the morning and supper at night."

Other comments suggested disorganization: "It's been kind of hectic. Things were not clean. It was kind of hard on both of us, particularly since he was having exams." "There are so many crises." "I did not know about the baby's crying, or how much 2 ounces were."

One mother who had felt that she would need no help said, "We believed this had been going on since the beginning of time, but we neglected to take account of the fact that members of the tribe might have helped out."

Independence was a characteristic of a few of these mothers: "I felt I could do it myself. I wanted to and did."

Other Maternal Relatives

In the 15 families which used "other maternal relatives" as principal helpers, these were, in order of frequency, the mother's sister, niece, and aunt, and her brother's wife. They were used significantly more frequently in the country than in the urban center. Only one of the fathers in these families was in a higher level occupational group, and only one had completed college. This group had the highest average number of additional helpers. The principal helpers did not take over responsibility for any particular task, but helped the mother with nearly all of her household tasks and with the care of the baby.

Favorable comments were: "My sister is smart. I was pleased she got here on time." "I did not mind asking her to do things." Adverse comments were: "My husband was just as good as my sister." "You get arguments from relatives." "My sister had children. She would bring them. There were too many here at once."

Paternal Grandmother

In the 15 families using the paternal grandmother as principal helper, the average age of both the father and the mother was below that of the sample. Some were families in which the father came from a family in which he was the only child or had no more than one brother or sister. Planning for the paternal grandmother's help was done well in advance.

The paternal grandmother took a somewhat more active part than did the maternal grandmother in the aspects of housekeeping that required management, such as preparing the shopping list, doing the shopping, and planning the meals. She also tended more to look after the father, getting his breakfast, for example. In nine of these families she also helped care for older children.

Comments of the mothers were: "I did not do anything during the day but take care of the baby." "My mother-in-law is good in that she did not do anything unless she asked us." "I do not like my mother-in-law to tell me how to take care of the baby. She would watch how I did things." One mother who had had the paternal grandmother come after the birth of each of her four children said: "My mother-in-law said she was coming. She always has her suitcase packed as soon as she knows. I would not ask her to come, but if she wants to I am glad. It was easy on the other children because it was their grandmother."

A Child

The seven families who used a child—a sister of the baby—as principal helper, all lived in rural areas. Five were in the lower educational and less skilled occupational groups. In these families the parents were older than the other groups.

Four of the mothers in this group had tried to make another arrangement, without success. There were no additional helpers except other children and the father. All of the child helpers were having vacations from school since it was summer. Their ages ranged between 10 and 17 years.

Four of the babies in these families had had symptoms of illness. Five of the mothers had health complaints themselves. One was rehospitalized because of an "infection inside," and in this case her sister then came and took over the work from the 13-year-old child.

The child helper helped her mother with the shopping list, but the father did the shopping. She helped prepare meals, wash dishes, clean house, and wash clothes for the family, although often the father took the laundry out. She and the other children fetched things for the mother, and in homes with no running water she often carried the water. She did not prepare the formula or bathe the baby, but she often fed the baby and changed his diaper.

Some of the mothers' comments were: "The child did surprisingly well." "My daughter was used to doing housework." "I had to keep after the children to do things." "The children wanted to play, like watching the water drop from the dishcloth."

The Next Time

The mothers were asked what arrangement they would make another time if they were not limited by insufficient money or living space:

- Of the 45 mothers who used the maternal grandmother, 19 said that they would do so again, but 21 said they would give consideration to paid help.
- The 22 mothers who had a paid helper all said that they would make the same plan again. Many had elaborate ideas for the extended use of the paid helpers; some would have two at this time, one for the day and one for the night.
- Of the 17 mothers whose husbands had been the principal helpers, 12 said that they would plan for additional help; of these 8 wanted a paid helper. But generally they wanted outside help only for a short time and mainly for specific jobs such as washing, ironing, or cleaning.
- The mothers in the 15 families using an "other maternal relative," by and large wanted their own people.
- The mothers using paternal grandmothers or other paternal relatives were scattered in their opinions, but most of them preferred a relative.
- The mothers using a child were unanimous in saying they would make different arrangements if they could.
- Many mothers added qualifications to their statements about plans for another time. They said that the kind of help depends on how you feel, how the baby feels, what your family has to give up in order to help, how congenial you are with the helper, and how you feel about outside people. There seemed to be general agreement that help is essential, but that plans must depend on conditions in the family.

Conclusions

In summary, the data collected have revealed that in one county in a Southern State: (1) the maternal grandmother is used significantly more than other kinds of helpers when the mother is younger than average, is having her first or second baby, and wants help not only with the housework but also with the care of the baby; (2) a paid helper is used significantly more by parents of higher educational and occupational levels; and (3) the pattern of "other maternal relative" is significantly associated with open country living. The data also suggest that other determinants in the choice of helper may be the relationship of the mother to her own mother, her husband, and the baby and the relationship of the father to his own mother.

One aspect, among many, in which this county may differ from others is in the amount of available domestic help. The time of year when the study was conducted introduced a seasonal bias; it is not known what the families that used a child as principal helper would have done had school been in session. Research expanded to include the opinions of other family members and helpers would add important insights. Also, a selection of mothers and babies with health complications would undoubtedly give a different picture.

From the point of view of the possible provision of professional and community help, the findings show unmistakably that the type of helper and kind of help needed vary with each family's characteristics and situation, not only with its material circumstances but also with its desires. The preference that many mothers expressed for paid help and the satisfaction of those mothers who had the services of "specialists" point to the need of a community resource which could make available to larger numbers this type of help. But the provision of such a resource without previous or accompanying counseling would meet only a small share of the need. The mothers of this study talked freely about the process of arranging for help and how it affected the division of labor within the household and relationships among family members. This indicates that conversation with an understanding person at an earlier date, of which only a few had had the opportunity, might have helped them to make plans which would have brought deeper satisfaction and contentment to them in this important phase of the life cycle.

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[1] Chenoweth, Alice P.: Post-natal period—general scope. *Journal of the American Medical Association,* January 30, 1960.

[2] Parsons, Talcott: Essays in sociological theory, pure and applied. The Free Press of Glencoe, Glencoe, Ill. 1949.

[3] Hellman, L. M. et al.: Early hospital discharge in obstetrics. *The Lancet,* February 3, 1962.

[4] Yankauer, Alfred et al.: Pregnancy, childbirth, the neonatal period, and expectant parents' classes. New York State Department of Health, Albany. 1958.

[5] Gordon, R. E.; Gordon, K. K.: Social factors in prevention of postpartum emotional problems. *Obstetrics and Gynecology,* April 1960.

Some highlights from the National Conference on Homemaker Services indicate . . .

THE BROADENED HORIZONS OF HOMEMAKER SERVICES

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THE PROBLEMS and possibilities of making homemaker service available to all who need it occupied the attention of more than 800 persons meeting in Washington, D.C., April 29–May 1, at the National Conference on Homemaker Services, called together by the National Council for Homemaker Services. Planning the conference was the first major activity of the year-old council, whose incorporation in December 1962 at the instigation of the now disbanded National Committee on Homemaker Service, the National Social Welfare Assembly, and the National Health Council brought to fruition a recommendation made 5 years ago at the 1959 National Conference on Homemaker Services for a continuing national mechanism for helping communities develop homemaker services.[1]

Among the conferees were doctors, nurses, social workers, public health and welfare administrators, home economists, board members, volunteers, and homemakers themselves, from public and voluntary and State, national, and local organizations throughout the country. Also attending were representatives from Canada, England, and Wales, including the president of the International Council of Homehelp Services.

Unlike the 1959 conference, this conference was purely a forum, with no recommendations intended or made by either the work groups or the conference as a whole. There were 80 speakers and panel discussants at 2 general sessions, 7 all day work groups, a banquet, an "early bird breakfast," and a luncheon. In addition, numerous persons presented ideas, opinions, and points of information from the floor.

That homemaker service is an essential service for every community is perhaps the one point of view that can be safely reported as being unanimously held by the participants. Other emphases, however, recurred repeatedly regardless of the topic of the session, indicating, if not unanimity, at least a widespread concern or interest. Among these were emphases on the importance of: teamwork among the professions in providing the individual or family with the kind of service needed; coordination of the homemaker service with other community services; flexibility in the provision of service; increased sources of financial support; use of volunteers in agency operations; realistic budgeting and cost accounting; and finding ways of bringing services to all income groups of the population.

While in this conference, as in the 1959 conference, the major concern was with unmet need, considerable evidence emerged from the sessions to indicate that the past 5 years have been marked by progress in the acceptance of homemaker service as a preventative and restorative service. Reports of activities told of not only a geographical spread, but also of a widened scope of use. The once-tense questions of "Under whose auspices should a homemaker service be given?" and "Is casework necessary?" seemed to have been buried—permanently or under a moratorium—thus diverting energies to such practical questions as "How can the various professions work together?" "How do you get a new program under way?" "Who is going to pay the bill and how?"

Expansion of Services

Despite the indications of marked progress in the development of homemaker services in the past 5 years, the conference was permeated by a sense of anxiety—a sense that progress was too slow to keep up with growing needs, and that something must be done about it. In fact, the opening speaker of the conference, Robert H. Collacott, president of the board of the Child Welfare League of America and vice president of the board of the Family Service Association of America, charged that "we seem to be losing ground" in attempts to strengthen family life. Ascribing the growth of need to the interdependence of modern society, he maintained

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A fuller report of the National Conference on Homemaker Services, now in preparation, will be issued by the National Council for Homemaker Services sometime in the fall. It will be available from the Council, 1790 Broadway, New York, 10019.

that services could only catch up with need if the modern corporation—"the dominant organization form of our society"—moved into a closer relationship with social agencies.

Over and over one heard the figure 200,000 as the number of homemakers needed in this country to do the job adequately. Ellen Winston, Commissioner of Welfare, U.S. Department of Health, Education, and Welfare, cited some statistics to contrast need and attainment: In 1963 there were 303 agencies known to be administering homemaker services throughout the United States, employing a total of 3,900 homemakers, most of them concentrated in a few areas; Great Britain, with one-fourth as large a population as the United States, has 55,000 homemakers. She stressed the opportunities for public welfare agencies to build up homemaker programs through Federal funds available under the Social Security Act, especially urging their use to improve conditions in families overburdened by poverty, illness, mental retardation, or inadequate homemaking skills.

Also at the opening session Norman A. Welch, M.D., president-elect of the American Medical Association, spoke of the growing number of chronically ill and of aged, whose medical care cannot achieve optimum effectiveness unless they have help at home. The medical profession needs "all the homemaker service you can offer," he said.

Descriptions of the ways States and localities have gone about planning the establishment or expansion of services brought out differences in approach and emphasis. For example:

- In North Carolina, where 40 county departments of welfare include homemakers in their budgets, the State welfare department underwrote demonstration services with the use of Federal child welfare services funds and foundation funds to get county programs under way—first for children in families facing emergencies, then for the chronically ill and the aged, and lately for teaching homemaking and child-care skills. The State welfare department now has two full-time supervisors of homemaker service on its staff to develop programs and recruit and train homemakers.
- In Massachusetts the State Department of Public Health assists in the establishment of local independent nonprofit homemaker services "with a generic emphasis" and helps to strengthen already existing services; and, on the theory that some counties are too poor to take over from a demonstration project, the department plans to subsidize services on a continuing basis. The department is drawing up minimum standards for homemaker service, seeking to develop broader financial support, and revising a State training program for homemakers to include pre-employment and inservice training activities for both homemakers and their supervisors.
- In New Jersey, under a mandatory State law the State health department helps to establish local health oriented homemaker services which are expected to become self-supporting.
- In Des Moines, Iowa, the Council of Social Agencies initiated plans for a homemaker service established in the county health department with Federal funds from the Public Health Service.

Broadened Horizons

The variety of uses of homemaker services described at the conference testified to an ever-widening view of the possibilities of this type of service. Something of the breadth can be judged from the varied auspices described—public health and welfare agencies, independently or in cooperative arrangements; voluntary family and children's service agencies; hospitals, both general and mental; and independent boards. There was even one service described which, although now a nonprofit board operated agency, was begun by an individual in her own home.

As described, these services were under direction of a variety of professions—social casework, medical, nursing, home economics and the supervision they provided the homemakers was similarly varied. The services also ranged widely in focus, scope, and flexibility. Some, especially those which were integral parts of hospital home-care programs, were called "health oriented" since they focused primarily on the needs of the patient. Others, referred to as "social problem oriented," focused on the family as a whole, with the primary purposes of keeping families together by relieving burdens and tensions in times of crisis, and, apparently more and more frequently, by using homemakers to teach "culturally poor" mothers individually, or in groups, or both, to learn how to keep an orderly house and take care of children. Almost invariably, "social problem oriented services" were reported as having casework direction and supervision.

A number of experiments were re-

Six brothers and sisters whose mother is incapacitated receive care and attention from an experienced home aide provided by the local visiting nurse association.

ported in reaching out to serve especially deprived groups of the population or families with special problems—agricultural migrants, people living in substandard housing, Indians on reservations, families with a mentally retarded child or a mentally ill parent, families threatened with eviction, families suspected of child abuse, and old persons living alone. For example, it was reported that:

- In New York City, the Department of Welfare sends homemakers into poorly housed families in situations "which at first glance seem hopeless" to help achieve better methods of household organization until better housing can be found for the family.
- The Bureau of Indian Affairs, U.S. Department of the Interior, has worked with State and county extension services, the U.S. Public Health Service, State welfare departments, and tribal councils in providing homemaker services to Indians on nine reservations.
- The Children's Aid Society of New York has found homemakers an invaluable tool to the caseworker in learning what the true conditions are in families suspected of abuse.
- The Evansville State Mental Hospital in Indiana has established a hospital-based homemaker service which has resulted in more cooperation on the part of patient and family, more accurate assessment of home conditions, and a better knowledge of the extent of the family's interest in the patient.
- The Retarded Infants Service, Inc., a voluntary organization in New York City, is sponsoring a demonstration project, with Federal funds from the Children's Bureau, through which homemakers from another voluntary agency, the Association for Homemaker Service, serve families with retarded children. One objective is to eliminate temporary placement of the child while the parents are trying to arrive at a decision as to the child's future.
- In Philadelphia the Friends Neighborhood Guild has carried out a controlled demonstration of the use of homemakers to improve housekeeping among families threatened with eviction from a low-rent housing project. The program also included a mothers' discussion group, casework visits to the homes, and discussion groups for teenagers and fathers.
- In San Francisco all the functions of the San Francisco Homemaker Service, a voluntary agency set up primarily to serve the aged, have been integrated with the services of the four local health centers of the city health department in a demonstration known as the Health Centered In-Home Services Project.

The concern with research in this conference was not on finding out whether the service is effective in helping to solve health and welfare problems—that fact, it was repeatedly maintained, has long ago been demonstrated—but in finding out "what kinds of homemaker services are most useful to what kinds of people under what circumstances." Thus research related to homemaker services was described and advocated as being related to demonstrations of new uses. Plans for such research, a research specialist warned, should be clear about what is being demonstrated and why, and about what will constitute evidence of success or failure, and should be realistic about the resources, knowledge, and techniques available and the limitations of the data produced.

Flexibility and Coordination

Flexibility, almost a catchword at the conference, showed up in the willingness of some services described to adapt duration and hours of service to need in spite of the difficulties in relation to staff and finances involved. Thus the director of one agency described the adjustments in homemakers' pay, staff schedules, and homemaker selection which had to be made in providing a 24-hour service.

Reports were also given of some agencies which provide homemaker services indefinitely in situations in which there is no prospect of imminent change in need. For example, in San Francisco a service begun for the care of the aged in time of illness "until their families could take over" was completely revised when it was found that many of the old persons needing care lived alone in rooming houses and hotels with no relatives available to give them the continued attention they needed.

The question of extended care, it was pointed out, often poses the necessity of choosing whether one client or many are to be served in agencies where finances and homemaking staff are insufficient to meet all requests.

Flexibility at the time of intake was also stressed to make need the chief factor in acceptance. "If the home is good enough for a child," said an administrator, "it is good enough for our homemakers."

"Teamwork" was also a catchword at the conference. More than one speaker pointed out that a homemaker service often uncovers other problems—an aged person needing medical attention, a child neglected or abused, a family threatened with disintegration because of marital discord—and that, therefore, there is an obligation for referral to the appropriate profession or agency and for coordination of the services. "Discreet and disconnected services are not the answer," said the director of a voluntary agency, advocating "programs which are geared to coordinated and continuous services of high quality, in which the choices are made in terms of what is best rather than what is cheapest."

Intra-agency teamwork was especially stressed in discussions devoted to hospital home-care programs in which doctor, nurse, and homemaker—and often also physical or occupational therapist—are all a part of the service. In most of these programs, as in a number of independent single-function homemaker services, agreements were reported to have been made with the medical and nursing professions as to the personal care tasks that could be carried out by the homemaker for the patient under appropriate private medical supervision.

Financing

Financing, the heart not only of expansion but also of continued existence, cropped up as an aspect of almost every subject discussed, drew overflow crowds to the meetings where it was the scheduled topic, and aroused considerable floor discussion. One opinion-splitting question was whether or not homemaker services, especially those which are "health oriented," could or should expect to become entirely self-supporting through fees received for services.

There were those who spoke for relating fees to costs, arguing against deficit financing or against giving homemaker services the aura of "charity." Pointing to services which had been able to collect from 75 to 95 percent of fees charged, they advocated that public welfare agencies or other community services be expected to purchase care for clients who cannot pay. One such advocate, however, expressed concern that the services in his State were for the most part "reaching those able to pay better than the indigent."

Others saw grants from public sources, foundations, service clubs, or charitable agencies as ways of meeting deficits. Some, mindful of low-income persons who do not come within the eligibility requirements of public welfare agencies, suggested that fees be based on ability to pay. And there were even suggestions that fees for solvent clients be set at an above-cost basis in order to build up a "kitty" to defray the cost of services to persons unable to pay.

One speaker suggested that under the 1962 amendments to the Social Security Act, which allow for 75 percent Federal reimbursement for homemaker services for recipients or potential recipients of public assistance, public welfare agencies are more apt to set up their own services than to purchase service, especially in regard to children needing substitute parental care. One reason for this he saw in the requirement that the public agency provide both the casework and the coordination in its homemaker service cases. He also predicted that the lack of an open-end appropriation for child welfare services and the availability of earmarked day-care funds may result in some tendency for the agencies to use day care where homemaker service might otherwise have been the service of choice.

The possibilities of other third-party payments, especially from Blue Cross or Blue Shield associations, received considerable attention, particularly in relation to payment for "health aides" in home-care programs administered from hospitals. Whether or not fees could be paid through such a source was said to depend not only upon the associations' own regulations but also upon the wording of the State legislation under which they operate. In Detroit, it was reported, Blue Cross will pay 50 percent of the home-aide fee—allowing for what is judged to be the "personal care" portion of the service. In Des Moines, Iowa, Blue Cross and Blue Shield payments for homemaker service are available to patients covered by a special senior policy.

Analysis of total costs (including gifts in kind) to determine the real cost per hour of homemaker service was stressed as important as a basis not only for fee setting but also for agency budgeting and policymaking. Cost areas which still need exploring were named as the cost of "guaranteed service," where this exists, of extending service beyond the 8-hour day, and of time spent on applicants rejected for service or for whom a homemaker was not available.

One value of knowing real costs was illustrated by a county welfare director who told of being able to produce figures from specific neglect cases to demonstrate to his board that putting teaching homemakers in some families not only may have a definite rehabilitative effect on the whole family, but also may be far less expensive than putting the children into boarding homes.

How volunteers can be used not only to bring the homemaker service community support but also to keep down costs was illustrated by a number of participants from New Jersey who told how local agencies there had recruited experienced women to carry out office tasks, such as bookkeeping, on a volunteer basis. Mrs. C. Rodney Stoltz, president of the Woman's Auxiliary to the American Medical Association, also stressed the variety of contributions that can be made by volunteers, particularly mentioning friendly visiting to shut-ins, manning telephone check systems, and providing transportation.

The Homemakers

Much of the effectiveness of any homemaker program depends upon the women giving the service. This was the basic premise of the papers and discussion throughout the conference and the reason for giving the 19 homemakers in attendance special recognition at the luncheon. The qualities sought for in the ideal homemaker were named repeatedly as acceptance of people, skills in home management, reliability, adaptability, flexibility, warmth, kindliness, maturity—these, it was said, were far more important than the number of years the homemaker had spent in school.

"We don't find the ideal homemaker—only the potential one," one speaker observed, adding that the homemaker's growth continues through training courses given previous to her employment and at intervals thereafter. Staff meetings and continuing supervision were also mentioned as important. In fact, speakers from both the health and welfare fields stressed adequate supervision of the homemaker as essential for a good program.

With this cheerful homemaker sent into their home to care for them in a time of family crisis, these children can draw on the strength of their own relationships to tide them over a difficult period.

Content of the training courses was reported as dealing with the effects of illness on people, health care, social services, care of children and the aged, and home management. The outline developed by the New Jersey health department in cooperation with Rutgers University was mentioned frequently.

Although most homemakers are women, a few participants said they were using male homemakers with considerable success, particularly with chronically ill elderly men. On an Indian reservation, it was reported, an elderly couple sometimes needs a man to do the heavy work such as cutting firewood and attending the infirm husband while the wife performs the usual household tasks.

Newspaper ads and news items were mentioned as a method of recruitment, but one participant reported that the friends of homemakers themselves were the best source of supply. A number of experiments were described of recruiting homemakers from the neighborhoods to be served, especially in service to low-income groups, in order to have homemakers who understand the culture and problems of the neighborhood, who speak the same language when the client is non-English speaking, and who understands what it is like to be burdened by poverty.

Warnings were given, however, not to expect too much of homemakers. "A homemaker can't go into a home and teach a mother to manage her money if the family's public assistance grant has been cut to 30 percent of need," said one discussant. And another: "There is a limit to the orderliness and cleanliness that can be established in a 2-room shack holding 10 to 14 people."

The conference itself contributed to the training of the homemakers who were in attendance. Through a special program planned by the Homemaker Services of the National Capital Area, they were taken by bus to the Columbia Lighthouse for the Blind, where they discussed ways homemakers might work with blind people; to the District of Columbia Welfare Training Center, where mothers in the local public assistance program are given vocational training in household skills; and to St. Elizabeths Hospital, where they participated in a psychodrama showing the homemaker in action in the home of a patient just discharged from a mental hospital.

The conference as a whole also had an opportunity to view a drama of homemakers in action. This was at the banquet where a new play, "To Temper the Wind," was presented for the first time by Plays for Living, and followed by a panel discussion. The play was preceded by a brief history of homemaker services presented by Katherine B. Oettinger, Chief of the Children's Bureau. Special honors were paid to the members of the former National Committee on Homemaker Service present at the conference.

In Closing

"We need as many trained homemakers as trained nurses," said Margaret Hickey, associate editor of the *Ladies' Home Journal*, the final speaker at the conference. And she challenged her audience with the questions: "Why don't we have more homemaker services? Have we given sufficiently high priority to the fact that homemaker services as we know them . . . are essential to all the other community services that make it possible for our community-wide family to keep going?"

Calling for recognition that voluntary agencies cannot do the job alone, she said: "Let's use tax dollars for the most essential human enterprise we have in this country, and that is the enterprise of the American home."

As the conferees dispersed many of them commented on the spirit of the conference, which Margaret Hickey had described as "a concern for the homes of this country." True, there were questions left unanswered, but there seemed to be a will to move forward, an awakened recognition of other professions, and an appreciation of the role that each might play. Many agreed with Mrs. Hickey when she said: "This was a good conference."

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[1] Morlock, Maud: A new look at homemaker services. *Children*, May–June 1959.

IN THE JOURNALS

Infant Mortality

Since the mid-1950's, national progress in reducing infant mortality has been close to a standstill, writes Eleanor P. Hunt in *Welfare in Review* for April 1964. ("Lags in Reducing Infant Mortality.") As in many of the advanced countries, reductions have taken place in the United States between the 1949–51 average infant mortality rate and that for 1959–61. However, this reduction was only 12.5 percent while in Finland the reduction (the greatest among the advanced countries) amounted to 48.8 percent.

The chief factor in the slowness with which the national infant mortality rate has declined in recent years, says the author, is "an uneasy balance between a decreasing death rate among white infants and a plateau or even a rise in rate among nonwhite." Since 1950, she adds, mortality differentials between white and nonwhite infants have increased.

Maternal and Child Health

Nearly one-fifth of all pregnant women are susceptible to rubella (German measles), a cause of malformations in the fetus, judging from the results of a study of 600 women made recently by the U.S. Public Health Service. The study was reported in the February 1964 issue of *Obstetrics and Gynecology*. ("Frequency of Rubella Antibody Among Pregnant Women and Other Human and Animal Populations," by John L. Sever, M.D., Gilbert M. Schiff, M.D., and Robert J. Huebner, M.D.)

The blood of 600 pregnant women was tested to find out whether it contained demonstrable antibody against the rubella virus; the investigators found that 17.5 percent of the women did not have the antibody and were therefore "at risk" for the infection.

The virus causes a variety of congenital defects in 20 percent of infants born to women who incur the disease during the first 3 months of pregnancy.

Danger in Utility Rooms

The March 28, 1964, issue of the *Journal of the American Medical Association* contains a report in its "Letters" section of five children badly burned in four separate accidents as the result of keeping gasoline for use in power lawnmowers and gas water heaters side by side in utility rooms. Calling a utility room holding such a dangerous combination of objects another type of deathtrap for children, the author suggests that parents be kept constantly aware of the dangers of keeping highly flammable solutions in the home, and of the importance of using leak-proof or explosion-proof containers for gasoline. ("Another Deathtrap for Young Children," John B. Blalock, M.D.)

A youth leader reports on . . .

THE NATIONAL CONFERENCE ON SMOKING AND YOUTH

R. BRUCE ANDERSON

Chairman, Youth Planning Committee
California Governor's Advisory Committee on Children and Youth

THE Surgeon General's report, "Smoking and Health", was a flare for an increase in smoking among young people.

Perhaps non-smooking could become the new status symbol.

These diverse expressions of two high school students were among the many opinions expressed at the National Conference on Smoking and Youth held April 30–May 2 at the National 4–H Club Foundation, Chevy Chase, Md., just outside of Washington, D.C., under the auspices of the Children's Bureau, U.S. Department of Health, Education, and Welfare.

Attending the conference were 115 boys and girls, aged 14 through 18, from 48 States, Puerto Rico, the Virgin Islands, and each of the 14 largest cities in the Nation, plus 10 high school and college students—including myself—who were work-group leaders and members of the Conference Planning Committee. The participants came from a variety of backgrounds—city, suburban, and rural, "privileged" and "underprivileged"—and of racial origins—Caucasian, Negro, American Indian, Japanese, Chinese, and Eskimo. Thus the conference served not only to recognize the relevance to youth of the Surgeon General's report on smoking and health but also to permit a real cross section of American youth to present its reactions to the issue of smoking and youth.

Planning the Conference

Earlier in the year the Children's Bureau had selected 10 high school and college students, also of diverse backgrounds, to serve as the Conference Planning Committee so that the conference might be planned by youth for youth. Early in March this committee met with the conference coordinator, Miriam K. Bazelon—first alone and then with consultants from the Children's Bureau, other Federal agencies, and national voluntary agencies—to determine the purpose and structure of the conference and to develop the procedures for selecting the young people who were to be its participants.

The differences in environmental backgrounds, levels of education, experiences with techniques of conference planning, and maturity of the committee's members contributed to good program planning for participants of such varied backgrounds. In its session with the consultants, the planning committee decided that the purpose of the conference should be "to reflect upon the issue of smoking from the perspective of the young people of America," rather than to present a plan of action. To achieve this end, the committee planned the kind of conference that would bring young people together to think both as individuals and in a collective sense rather than to react passively to presented suggestions.

The Children's Bureau had committed itself to providing the funds to meet the costs of transportation and lodging for each participant so that young people from all parts of the Nation could attend the conference, regardless of their financial means. The Conference Planning Committee responded to this unique opportunity for selecting participants of diverse racial, religious, and social-cultural backgrounds, and suggested appropriate procedures in order to meet this goal. The committee also stressed the importance of giving the participants responsibility for conducting their own discussion-group sessions.

What They Said

At the first formal session of the conference, on the afternoon of April 30, Katherine B. Oettinger, Chief of the Children's Bureau, expressed the hope that the conference would "provide some very specific guidelines about what the Children's Bureau can do and should be doing about the smoking question . . ." and that it would enable the Bureau "to carry your message in your own words to other young people through the report of the conference, which will be called *Youth Speaks Out on Smoking*."

Following a speech by Johnny Unitas, in which the football star emphasized the effect of smoking on the performance of an athlete, Senator Maurine B. Neuberger of Oregon confronted the young people with the significant question of whether or not our Government is equal to the task of establishing the authority needed to bring the hazards of smoking under control. Dr. Daniel Horn of the U.S. Public Health Service summarized the medical research findings on smoking and health, findings which were later visually supported by a showing of the American Cancer Society's film, "Is Smoking Worth It?"

For a day and a half the participants were divided into 10 discussion groups, each with its youth leader and recorder, and an adult consultant. In these discussion sessions the young people spent considerable time probing the reasons why people smoke and why they do not smoke. They not only presented the feelings of members of their own generation but at times felt compelled to assume the role of a parent. They also considered: problems related to the nature of the practice and habit of smoking; the necessity for young people themselves to reach their own understanding of the issue of smoking and youth; and possible effective means to reduce cigarette smoking among young people.

Several discussion groups came to an emphatic conclusion that the problem of smoking and youth was directly connected with the influence of the home. One group made the distinction between the parent who informs his child that "I will let you choose, but I care," and the parent who says "Do anything you want, I don't care."

Another concern prevalent in the discussion groups was with the personal attitude of the young person when faced with the decision of whether or not to smoke in the presence of others who do smoke. A student from the Virgin Islands remarked that "I eat lemon drops for a substitute, because someone without a cigarette is at a psychological loss." Of those who did decide to smoke under such conditions, one participant said that a cigarette "is like a good buddy in times of stress"; and another that he regarded cigarette smoking as "one of the few things which are really my choice."

In these discussions the young people seemed to come gradually to recognize that smoking was a symptom of many things—a means of easing tension, of reaching for status. Individuals varied, but a number of participants seemed to come to a realization that they did not want to be controlled by a habit. "Bull session" discussions in which there was an interplay between smokers and nonsmokers produced indications of personal convictions.

While the quality and quantity of the issues which underwent perusal varied from group to group, it was obvious that the participants recognized the problems of thinking and working together. Several group leaders observed that the involvement of the consultant became necessary only when questions arose concerning the distinction between the physiological and psychological aspects of smoking and the human being, in situations of either a personal or a social nature. Other groups accepted and used the consultant as an integral part of the flow of discussion.

In Summary

Roy Sorenson, chairman of the National Committee for Children and Youth, summarized the conference at the closing session on Saturday, May 2. Through continuous contact with the group leaders, Mr. Sorenson had reached a synthesis and perspective of the conference. He made some acute observations about underlying currents and tendencies of the "work" of the conference: "This conference has had something to say to us about our times . . . something to say to us about change."

Often frustration in group discussion resulted when the young people were reminded that change does not come easily, Mr. Sorenson observed. "Built-in attitudes do not readily change with the logical need for it."

Mr. Sorenson also pointed out that such fundamental issues had real meaning for the young participants, for the issue of smoking and youth demanded exploration of attitudes among young people, of sensible approaches to the problem from the standpoint of the individual or the "trend of the group," and of the kind of responsibility carried by both parent and child in the home.

Mr. Sorenson noted the observation made by many of the participants that there was a marked absence of young smokers at the conference. He also called attention to the fact that the heavy concentration on smoking as a personal matter tended to obscure some of the social implications of smoking. Lastly, he expressed the opinion of the participants that an almost exclusive concern over the equation of smoking with lung cancer called for greater attention to other effects of smoking on health.

In general the conference participants directed themselves to the idea of how to make nonsmoking the respectable and acceptable attitude among young people through education of both smokers and nonsmokers. The intention of the planning committee had been to allow the young people of America to present their ideas on the issue of smoking and youth. The "work" of the conference produced the feeling among youth and adults alike that the young people had intelligently addressed themselves to some crucial problems in all phases of the issue. There seemed to be general agreement with Mrs. Oettinger's evaluation at the final session that ". . . the National Conference on Smoking and Youth offered us a memorable opportunity to think together."

BOOK NOTES

SCHOOL HEALTH SERVICES. Charles C. Wilson, M.D., editor. National Education Association, Washington, D.C., and American Medical Association, Chicago, Ill. 1964. (Second edition, revised and rewritten.) 414 pp. $5. Discounts on quantity orders.

This guide for health procedures in school systems brings up to date the material presented in an earlier edition, published in 1953. Both editions were prepared by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.

As a companion volume to two other publications of the Joint Committee, "Health Education" and "Healthful School Living," it describes responsibilities of schools for health appraisal, health counseling, prevention of accidents and communicable disease, emergency care, sanitation, and health protection of school personnel. It emphasizes the need for coordination of school efforts with those of parents, departments of health, private physicians and dentists, and community health agencies.

GUIDANCE AND THE SCHOOL DROPOUT. Daniel Schreiber, editor. The National Education Association and the American Personnel and Guidance Association, Washington, D.C. 1964. 267 pp. $3 clothbound; $2 paperback. Discount on quantity orders of two or more.

This book includes 12 papers given at a symposium on problems of the school dropout. The participants discuss such subjects as guidance in the elementary school years as a step toward holding students in school during their future high school years; organization and administration of the school guidance program; cooperation of the program staff with teachers, parents, and the community on the whole; the job market for graduates and for dropouts; continued guidance for dropouts after they leave school; and professional preparation of counselors of school children.

Some of the evidence quoted in the report indicates that in schools with organized counseling programs the dropout rate decreases and that, when counseling continues after students drop out of school, many either resume their formal education and graduate—from their own school or another one—or earn an "equivalent" diploma.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Volume XVIII. Ruth S. Eissler, Anna Freud, Heinz Hartmann, and Marianne Kris, editors. International Universities Press, New York. 1963. 662 pp. $10.

Includes three sections, "Contributions to Psychoanalytic Theory," "Aspects of Normal and Psychological Development," and "Clinical Contributions," as well as a list of the contents of previous volumes.

DETERMINANTS OF INFANT BEHAVIOR II; Proceedings of the second Tavistock seminar on mother-infant interaction, held under the auspices of the Ciba Foundation at London, September 1961. B. M. Foss, editor. Foreword by John Bowlby. John Wiley & Sons, New York. 1963. 248 pp. $7.75.

This book reports on the second seminar in a series on the subject, the first of which was reviewed by Leon J. Yarrow in the January-February 1963 issue of CHILDREN. Included are reports on animal studies, human studies, and research techniques. The investigators were psychologists, psychiatrists, psychoanalysts, zoologists, a neurophysiologist, and an obstetrician.

Among the reports on animal studies is a paper in which Harry F. Harlow describes his further experiments with monkeys raised with cloth or wire mother-surrogates. He reports on the maternal behavior of a few "nonmothered monkeys" who in respect to their own infants were "completely indifferent" or "violently abusive."

Among the studies on human behavior is a continuing one in which H. F R. Prechtl observed 1,000 newborn infants with a history of prenatal or paranatal complications and found that 15 percent of them were slightly brain damaged. He notes that the mother of a brain-damaged infant usually did not realize that there was anything wrong with the baby, but blamed herself for his deviant behavior.

Among the papers on method and theory are reports on infants' exploratory behavior, social attachments in infancy, and development of social responsiveness.

CHILD PSYCHOTHERAPY: practice and theory. Mary R. Haworth, editor. Basic Books, New York. 1964. 459 pp. $8.50.

Addressed to both practitioners and students of clinical psychology, child psychiatry, and social work, this book includes 45 papers, mainly concerned with the individual treatment of neurotic children in the 5- to 12-year age range. They discuss the selection of techniques; situations encountered in therapy, such as the handling of aggression; the therapeutic processes; the symbolism of play; and evaluation of the patient's progress and of the techniques.

The editor warns that some of the procedures discussed would need to be modified or avoided in working with the seriously disturbed child.

THE FAMILY AND HUMAN ADAPTATION. Theodore Lidz, M.D. International Universities Press, New York. 1963. 120 pp. $3.

Three lectures addressed to psychiatrists, anthropologists, psychologists, sociologists, and members of allied professions are included in this book.

The first examines the thesis that the nuclear family, despite its paucity of stabilizing forces, is better suited than is the extended-kinship family for preparing its children to live in a society that is rapidly changing its adaptive tactics. The author finds "indications that the family in the United States, even though perplexed and floundering, is regaining strength and vitality."

The second and third lectures offer an approach to the question of what the family must provide to assure adequate adaptive capacities and ego integration in its offspring.

HERE AND THERE

Joint Conference on Children and Youth

How to bridge the gap between demonstration projects and the main stream of services for children and youth occupied the attention of 456 delegates, including 43 young people, from national youth-serving organizations meeting at the Joint Conference on Children and Youth in Washington, D.C., April 6–8. The conference was the joint undertaking of the Council of National Organizations for Children and Youth, the Interdepartmental Committee on Children and Youth, the National Council of State Committees for Children and Youth, and the National Committee for Children and Youth, with the latter acting as the coordinator.

Charging that the values learned from the numerous "reaching-out" research and demonstration projects of recent years had not penetrated into the mainstream of our services, Roy Sorenson, chairman of the National Committee for Children and Youth, opened the conference with a plea that the participants look for ways their own institutions might change. His point was underscored by Frank Riessman, consultant to Mobilization for Youth, New York, who identified one of the outstanding products of the recent "reaching-out" demonstrations as a growing realization of "the strengths of the poor."

Dr. Riessman told of a variety of experiments in using nonprofessional persons from low-income neighborhoods as the providers of direct services under professional supervision—as parent aides who serve as liaison between the school and distrustful parents, as family aides in clinics and social agencies, as teacher aides, as tutors of fellow students. Rapport between helper and helped is more easily reached, he maintained, when the two have faced similar experiences, and often the helper is helped as much as the person served.

Other outstanding findings of today's demonstration projects Dr. Riessman identified as the importance of training teachers to work in low-income neighborhoods; of gearing work training programs for young people to jobs likely to lead to careers; of opening such programs to young people of low as well as of high ability; and of mobilizing the poor themselves for social action. He named three elements as vital in a strategy of change: (1) developing task forces that break through the different levels of "the establishment"; (2) developing negotiators who can deal with the power structure; and (3) concentrating on one goal at a time.

Commissioner of Welfare Ellen Winston at the dinner meeting maintained that the success of programs to improve opportunities for youth outside the home will largely depend on the expansion and strengthening of services that reach into the home to protect the preschool child.

In 10 work groups the conferees concentrated on how to penetrate the barriers to effective services in specific areas—physical health, employment, education, infants and preschool children, the mentally retarded, mental health education, youth participation in community affairs, disadvantaged children and youth, family living patterns, and physical and social planning.

Difficulties in communication loomed large among the obstacles they named—between the services and the public at large, between professional persons of middle-class background and the socially isolated poor, between youth and adults. Other obstacles mentioned were lack of resources in areas of greatest need; fear on the part of those needing services; personnel shortages; a tendency to exclude State agencies in planning for federally aided community demonstration projects for which the State will eventually be expected to "pick up the tab."

The use of untrained but supervised help also received considerable attention in the work groups, with examples being cited of the use of indigenous leaders to interpret or even to help develop programs, and of high school or college students to tutor "non-achieving" children. Also emphasized was the importance of taking services into slum neighborhoods—through mobile clinics, store-front offices, and home visits.

The youth delegates participated actively in all the work sessions—telling of their own community activities, such as serving as tutors, working on community action committees, participating in recreation or friendship programs for institutionalized children. They had suggestions—"Why don't we invite some 'bigoted youth' to our meetings so that we will know what they are like?"; complaints—"You adults are so preoccupied with upward-striving you aren't making contact with us"; and queries—"Where can I go to meet my peers on all levels, not just those in my own organization?"

At the closing general session, Senator Claiborne Pell of Rhode Island advocated efforts not only to improve opportunities and environmental conditions for youth, but also to provide them with challenges calculated to produce a spirit of trying to go "the extra mile."

In summarizing the entire conference Mrs. Thomas J. Herlihy, Jr., former chairman of the National Committee for Children and Youth, cited communication, interpretation, involvement, and coordination as the "ABC's of working with people for people" which had been identified by the conferees.

Against Delinquency

A 3-year demonstration program to combat juvenile delinquency was recently begun in the "inner city" of St. Louis, Mo., with Federal support from the Office of Juvenile Delinquency and Youth Development in cooperation with the President's Committee on Juvenile Delinquency and Youth Crime and funds from other Federal agencies, the State and city governments, and private sources. The target area has more than 100,000 residents, 55 percent of them nonwhite.

Eight neighborhoods in the area are to have "neighborhood stations," each to be operated by a coordinator of the health, welfare, recreational, and employment services available to the neighborhood. In most of the stations a committee of neighborhood residents will be appointed by the coordinator to advise on planning and operations.

In each of these neighborhoods, five employment and training centers will be set up as out-stations of the Youth Services Division of the Missouri State

Employment Service. Schools in the area are offering special classes for "low achievers," reading clinics, a preschool program, counseling, a tutorial program for suspended and other difficult students, efforts to bring back school dropouts, parent orientation, and classes for potential delinquents.

A program of youth groups includes recreational activities, tutoring, camping, and leadership training. Adjudicated delinquents are being permitted by courts to join one of the youth groups in lieu of being put on probation.

A housing improvement program will be directed at motivating residents to join in efforts toward safety and sanitation.

The project's health phase will include identification of factors deterring use of health services; health education; multiphasic screening and follow-up; and coordinating, modifying, and expanding services.

The project, called the Human Development Planning Project of St. Louis, is being carried out by a nonprofit corporation, which is directed by a board that includes the Governor, the mayor, the HEW regional director, and local business and labor leaders. The 15-month preparation for the project was done jointly by the St. Louis Welfare Department, the Health and Welfare Council of St. Louis, and the Metropolitan Youth Commission of St. Louis City and County, with a grant from the Office of Juvenile Delinquency and Youth Development.

Merging with the Human Development Planning Project is the "concerted services" project sponsored by the Joint Task Force on Health, Education, and Welfare Services and Housing in the neighborhood of the Pruitt-Igoe housing development (see CHILDREN, November–December 1962, page 242).

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Since 1962, when an improvement program in police work with juveniles was begun in Pennsylvania by the State government and the Pennsylvania Chiefs of Police Association, the number of police departments with full-time specialists in juvenile work has increased from 15 to 40; and the number of staff members in such juvenile units from 225 to 350. The State Department of Public Welfare and the Public Service Institute of the State Department of Public Instruction are cooperating with the Pennsylvania Chiefs of Police Association in training 1,000 police officers a year for work with juveniles. The State Department of Public Welfare provides grants to the 40 police departments with full-time juvenile units for 2-week in-residence training institutes.

Research Grants

Adopted children, children in day care, those in family situations which may lead to delinquency or emotional disturbance, mentally retarded adolescents, and unmarried parents are the focus of a number of child welfare research grants made by the Children's Bureau early this spring. The 10 grants, which go to nonprofit organizations, are the fifth series of grants made since the program was authorized by the 1960 amendments to the Social Security Act.

Included are grants to:

- The Upstate Medical Center, State University of New York, for developing a demonstration day-care center for socially and culturally deprived children between the ages of 6 months and 3 years.
- The University of Michigan, for continuing experimental group work with foster parents, employed mothers, and mothers assisted through the Federal-State program of aid to families with dependent children.
- Howard University, to demonstrate how a group day-care program, combined with parent education, can improve the readiness of deprived children for schooling.
- The University of Wisconsin, for a study of factors contributing to success or failure in the adoption of older children.
- The Vista Del Mar Child Care Service and the Research Service Bureau of the Jewish Federation Council in Los Angeles, for continuing a study of the unmarried father.
- The Jane Addams School of Social Work at the University of Illinois, for continuing a study of ways to train nonprofessionals for licensing day-care and foster homes.

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Among the 19 State public assistance demonstration projects for preventing or reducing dependency that have been approved by the Welfare Administration of the U.S. Department of Health, Education, and Welfare up to May 1, 1964, nearly all affect children—most of them directly, others through their families.

Some of the projects are planned to induce dropouts to return to school, some to enable young people to gain summer employment experience, some to improve family conditions through social casework, some to give more training to public assistance workers. One, in Alaska, is for rehabilitation after a natural disaster.

The projects, which are being carried out in 16 States, are authorized by the 1962 Public Welfare Amendments to the Social Security Act. They are supported by the State welfare departments with a Federal reimbursement of 50 to 100 percent, depending on the type of project.

In the Alaska project about 180 families in the program of aid to families with dependent children who are in the areas of the recent earthquake will receive an average of $47 more per month in assistance payments. An estimated 63 additional families, including families with fathers in the home, will qualify for such aid because of disaster-induced unemployment.

The Federal Government is paying 100 percent of the cost of the project—$385,000—which will be administered through Alaska's State Department of Health and Welfare. One purpose of the project is to learn ways of increasing the effectiveness of efforts to help people in a major natural disaster.

Child Welfare Training

In mid-March the Children's Bureau awarded its second series of child welfare training grants. The grants, which go to public or other nonprofit schools of social work and other institutions of higher education offering courses of study that will prepare students for work in the field of child welfare, include 276 traineeships to support graduate education leading to a master's degree in social work, as well as 12 traineeships to support training beyond the master's or study leading to the doctoral degree.

Other grants, called teaching grants, will enable 50 schools of social work to employ 54 instructors for field work training and 4 classroom instructors.

The new child welfare training grants will also finance 19 short-term training projects, which include seminars, workshops, institutes, and other training activities shorter in duration than a semester of a regular academic year.

The grants were authorized by the 1962 Public Welfare Amendments to the Social Security Act. The child welfare training projects in the first series were awarded in 1963.

At present only about half the counties in the United States have trained child welfare workers.

Nutrition

Nutrition services for children who are in group care and ways to extend and strengthen these services were discussed at a workshop held in Hartford, Conn., April 28–29, under the sponsorship of the Children's Bureau and the Connecticut State departments of health and welfare. The workshop was attended by 22 dietary consultants and nutritionists from health, welfare, and mental health agencies in the States included in Regions I and II of the U.S. Department of Health, Education, and Welfare: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

The participants discussed nutrition services for children in day care, in institutions for the mentally retarded and for dependent and neglected children, and in other programs for group care.

Speakers represented not only the field of nutrition, but also the fields of child welfare, pediatrics, and administration of group care services for children. Among the points discussed was how children away from home may have special needs superimposed on their basic developmental needs. Also stressed was the mutual dependence of the various agencies and disciplines in improving group care.

Foster Care

To help public child welfare workers learn to give better service to children and their families and to determine what the quality of foster care is at this time, the Children's Bureau has begun a 3-year project based on intensive study by foster care workers of cases that they have handled. The project is being carried on in nine public child welfare agencies, one in each of the HEW regions.

The worker is aided in his study of each case by a schedule outlining the factors to be considered in dealing with the child and his family and also by a statement regarding basic premises in foster care. After the worker and his supervisor review the worker's report on his practice in the case, the case is studied by a representative of the State public welfare agency and, separately, by the Children's Bureau foster care consultant in preparation for a consultation conference between the child welfare worker, his supervisor, the State representative, and the Children's Bureau consultant.

At the consultation conference the group draws upon the schedules to identify principles, concepts, and methods which can be used by the worker in other foster care cases.

The present phase, which began in January of this year and will end at the end of November, is reviewing intake records of first admissions to foster care. The second, extending from December 1964 through November 1965, will review placement decisions, services during foster care, and case closings. The third, which will cover the period December 1965 through November 1966, will review cases in which the agency, instead of placing the child, has worked with him and his family at home.

Indian Youth

This summer for the third time State agencies in Minnesota are cooperating in a summer-job, counseling, and training program for Indian youth of the Red Lake Reservation in northern Minnesota, called the Indian Guide Program. The 2-month program will involve about 25 high school students, including both boys and girls, most of them sophomores and juniors. The boys and some of the girls will guide tourists to points of interest on the Red Lake Reservation, while other girls will serve as hostesses at the Tourist Bureau of the Chamber of Commerce, Bemidji, Minn., explaining an exhibit of Indian artifacts.

In addition to their salaries of $80 a month, the guides receive uniforms and their board and lodging in a dormitory of the Bemidji State College, rooming with regular college students. Counselors live with the guides throughout the program. Vocational tests and guidance are given, tours are made of various industries and businesses in St. Paul and Minneapolis, a tape recording machine is used to improve verbal skills, and group experiences are provided through ceremonies and special events as well as through participation in college functions.

The experience of previous years has shown that the guides develop increasing initiative, poise, and self-confidence. In the past 2 years all guides have continued in the program throughout its duration.

Coordinated by the Minnesota Governor's Advisory Council on Children and Youth, which is staffed by the Youth Division, Minnesota Department of Corrections, the program is financed by the Minnesota State Department of Public Welfare and the Bureau of Indian Affairs, U.S. Department of the Interior. Representatives of community organizations, industries, and businesses cooperate.

Youth Employment

As part of a larger program in which 1,100 boys and girls 16 to 18 years old were placed in summer jobs last year, staff of a demonstration project in Washington, D.C., assembled information on 54 of the youths, who were from families receiving public assistance, to learn how they responded to the opportunity for employment. Also, their employers were asked for written statements concerning the youths' job performance and about their own attitude toward rehiring them.

The project was operated by Washington Action for Youth (WAY), which receives Federal funds through the President's Committee on Juvenile Delinquency and Youth Crime. (See CHILDREN, November–December 1963, p. 242.) Cooperating with WAY were the U.S. Employment Service, the District of Columbia Public Schools, the District of Columbia Department of Recreation, and the Washington Urban League.

The work was chiefly manual, paying $1.15 to $1.34 per hour; the jobs lasted 8 weeks.

An important indication of the favorable reaction of the youths to the opportunity for employment, according to the research director of the project, is that 7 out of 10 remained on the job for the full 8 weeks. Only 3 were known to have been discharged, although 12 left the job for undisclosed reasons.

Employers reported that a few youths presented problems, such as absenteeism or tardiness, but most of the youths performed at high or average levels. The employers of four out of five of the young people also stated that they were all well enough satisfied with the youths' work that they would rehire them.

At the request of the District of Columbia Department of Public Welfare, the Welfare Administration of the U.S. Department of Health, Education, and Welfare waived a Federal rule requiring that the amount of the youths' earnings be deducted from their families' assistance payments. (This was the first such waiver authorized under the 1962 Public Welfare Amendments to the Social Security Act.)

The summer employment program is being repeated in 1964.

Miscellaneous

To help children in minority groups overcome the effects of failure caused by poverty and segregation, Bank Street College of Education in New York City is planning to open, on an experimental basis, an educational resources center which will work in cooperation with the city public schools. The center, which will have the support of a grant from the Carnegie Corporation, will be devoted entirely to the development, collection, and dissemination of new instructional materials, new teaching methods, and curriculum innovations, specifically designed to raise the achievement of educationally handicapped children of minority groups at all grade levels. At first the center will work directly with 20 elementary schools and 4 junior high schools; eventually the program will involve 31,000 children and 2,000 teachers.

. . .

As a result of an increasing concern among Federal agencies about the needs of adolescent girls, the Interdepartmental Committee on Children and Youth has created a Subcommittee on Services for Adolescent Girls. Under the chairmanship of Rose Terlin, Women's Bureau, U.S. Department of Labor, this subcommittee is considering various approaches to discovering the means for interrupting and perhaps eliminating the cycle of impoverishment among socially deprived adolescent girls. Information from member Federal agencies of ICCY and voluntary agencies is being collected before determination of the eventual focus is finally made.

. . .

With a grant of $90,000 from the Field Foundation to study the problems of unmarried mothers and their children and to provide a centralized information and consultation service for agencies and communities in dealing with these problems, the National Association on Service to Unmarried Parents (NASUP) affiliated early in May with the Child Welfare League of America and the Family Service Association of America. NASUP's activities will henceforth be jointly administered by the two national voluntary standard setting agencies in the family and child welfare fields, with the League providing office space.

. . .

Robert L. Sutherland, director of the Hogg Foundation for Mental Health, University of Texas, has received a grant of $550,000 from the Ford Foundation for a study and action program related to philanthropy in the Southwest. This study will focus on community programs for youth and will carry matching grants in cooperation with grants from privately endowed foundations in the Southwest, to be utilized toward improvement of youth opportunities. Bernice Milburn Moore is the project's associate director.

READERS' EXCHANGE

SIMSARIAN: *Suburban foster care*

Frances Simsarian's article, "Foster Care Possibilities in a Suburban Community" [CHILDREN, May-June 1964], confirms some of the impressions that we at Illinois Children's Home and Aid Society have gained through an activity we call the "West Suburb Project."

In an attempt to obtain foster homes some months ago, we established the West Suburb Project to try to determine whether (1) individuals in the community gained a genuine awareness of foster care programs and the need many children have for foster parents through existing mass media of interpretation; (2) the number of foster home applicants in the upper income groups could be increased and latent interest on the part of suitable couples realized; (3) through ongoing individual contact and interpretation within a selected community we could explode some of the myths and misconceptions about agency foster care and develop more suitable applicants over a long period.

Our design called for selecting an accessible community with a low mobility rate; good community resources such as schools and playgrounds; a large proportion of married couples in their thirties or forties, with at least high school education, annual incomes of $5,000 or more, and living in single family dwellings; and a low percentage of children under 3 years of age. We selected West Suburb through use of the 1960 Bureau of the Census material and through individual conferences with representatives of such organizations as the Welfare Council of Metropolitan Chicago, the Church Federation of Greater Chicago, and the county department of education.

Initially we talked with representatives of local church, social, and civic organizations, our plan being that through ongoing contracts we would develop an informed interest group able to disseminate better knowledge of the agency foster care program, arrange speaking engagements for us, help us in understanding community attitudes, and give guidance as to approaches within the community in recruitment of homes. The next step planned is to carry out a survey of individual married women through use of a questionnaire or by personal interviews to determine if interest could be developed on the part of some in being potential foster parents, to be followed by interviews with those individuals showing such an interest. To date our project has been well received and supported. We have met with individuals and some community groups. As yet a cohesive working group from the community has not been fully established.

Our impressions to date are similar to Mrs. Simsarian's findings. We believe that further exploration should be made regarding the importance of potential earnings as foster parents to families in such neighborhoods and the various advantages to the agency of interesting them in the program.

Virginia Myhre Ruttan
Supervisor, Homefinding Department, Illinois Children's Home and Aid Society, Chicago

HUNT: *A stimulus to research*

J. McVicker Hunt's article, "How Children Develop Intellectually" (CHILDREN, May–June 1964), properly "shakes out" a good many notions in psychology which stalled much research in child mental development following the classic studies of environmental effects on intelligence in the 1930's. Dr. Hunt has given an historical perspective to much of the work being done in cognitive research today, and also has accomplished the difficult task of projecting some theoretical models from which studies in preschool programs can emanate.

I am somewhat concerned, however, over Dr. Hunt's comments relating to the precedence of cognitive factors over emotional factors in early childhood development. In pursuing this course, there is danger of substituting an entirely new set of principles for older ones, instead of building on the positive aspects of earlier theories. Debating the importance of emotional *vs.* cognitive factors can lead to the same meaningless arguments that have been waged over other false dichotomies, such as mind-body and heredity-environment.

The studies Dr. Hunt cites from Goldfarb point out the necessity of a wide variety of early experiences derived from interaction with persons in the environment. Without such stimulation the child withdraws into an unresponsive, "cold," and dull human being who lacks *both* emotional security and cognitive skills.

Dr. Hunt's article raises many researchable questions. His reference to crucial years for cognitive development suggests that during these years there may be critical periods and importance in certain ordering of experiences for the child. Investigations during the crucial years can be done with many groups of children. At our preschool for mildly retarded children we have observed that certain patterns of functioning, such as handedness, are often difficult to establish when there has been prolonged indetermination. The differential effects of readiness, stimulation, and training may be studied in this and other settings.

Dr. Hunt's paper should stimulate much research within the increasing number of programs for preschool children who live in poverty-stricken areas.

Donald K. Freedheim
Clinical Psychologist, Mental Development Center, Western Reserve University

MONTGOMERY: *Is this the best way?*

The imagination and courage demonstrated in the reorganization of the Spence-Chapin Adoption Service, New York, to meet the challenge of the manpower shortage in social work are indeed impressive. ["Differential Utilization of Social Work Personnel," by Helen B. Montgomery, CHILDREN, May–June 1964.] The re-thinking of the agency's practices, the carefully planned use of regular staff, the expanded graduate student training program, and the addition of a large number of "work-study students" to the staff resulted in an increase in service to clients. Nevertheless, in the absence of more details than were presented, several questions arise.

"Change in workers is built-in at Spence-Chapin by plan," Miss Montgomery reports, adding that "appropriate use of different staff members, at crucial stages in the casework process in adoption (intake, home study, supervision, and finalization of the legal process), provides for greater specialization in particular aspects of each process." She also mentions other valuable byproducts from such differential use of staff. However, I believe we need to assess more carefully what has been gained against what it has cost and who has paid for these changes in workers.

Miss Montgomery indicates that the planning for changes in workers was motivated primarily by the shortage of professionally qualified workers. We may decide that this is sufficient justification. Is it, however, also then necessarily valid justification for "forsaking the long-held beliefs that 'it is always good for a client to have one worker' . . . ."?

Adoptive applicants come to the agency for a child and see the process as a whole, from the first inquiry through the legal adoption. Those of us who, for administrative or other reasons, find it best to separate the intake interviews from the rest of the adoption process have learned what the loss of the intake worker can mean to the applicants, no matter how well prepared they are for the change. Moreover, if the caseworker's role with adoptive applicants is to be a therapeutic one, then its base is the client-worker relationship. Changes of worker interrupt the client-worker relationship, dilute it, and affect the client's capacity to use it. It would seem to me important then to be aware constantly of the meaning of these changes to clients and also to plan for some later followup and evaluation of the results.

I would wonder too about the effect of these worker changes on the student training program. Generic learning in the fieldwork placement is already more difficult in any agency with highly specialized services and caseloads. Where fieldwork experience is then only in a fragment of a specialized service, there can be many questions of its value. Are we training adoption workers or partial adoption workers or child welfare workers or caseworkers?

The many details of the program described serve to remind us that an agency which seeks to improve its service, qualitatively as well as quantitatively, must begin with a review of its goals and philosophy, and then ask itself, "Is this the best way?" in relation to structure, staffing, and all phases of practice. For this we are grateful.

Johanna G. Schenk
Chief Supervisor, Adoption Department, Boston Children's Service Association

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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HOMEMAKER SERVICES IN PUBLIC WELFARE. Department of Health, Education, and Welfare, Welfare Administration, Office of the Commissioner. April 1964. 15 pp. 10 cents.

Addressed to laymen and professionals, this booklet uses 22 captioned photographs to tell about the variety of needs met by homemakers provided to families and their children, the chronically ill, the disabled, and the aged. It also describes the types of Federal financial aid available to State public welfare agencies to help strengthen and expand the homemaker programs operated by State or local agencies.

IT'S YOUR CHILDREN'S BUREAU: the Bureau's current programs. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 357. Revised 1964. 79 pp. 30 cents.

This is a revision of a 1962 publication which tells the story of how the Children's Bureau activities have helped to develop and provide a variety of specialized health and welfare services to meet the needs of children and their families. New material describes the Bureau's areas of responsibility for the broadened programs in child welfare, crippled children's services, and maternal and child health authorized under the 1962 Amendments to Title V of the Social Security Act and under the Maternal and Child Health and Mental Retardation Planning Amendments of 1963.

HOMEMAKER SERVICES; history and bibliography. Maud Morlock. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 410. 1964. 116 pp. 40 cents.

This publication features an annotated bibliography of material published on homemaker services in the United States since 1913, dividing into sections 517 selected references, of which 213 appeared between 1960–64; and it incorporates 60 references on services in other countries. Included, among other sections, are: historical background; the role of professional workers; meeting special needs; training; guidelines and standards; appraisal of services; and finances. The publication also presents a résumé of the history of homemaker services in this country, pointing up the development and modification of such services over the years.

FEEDING MENTALLY RETARDED CHILDREN; a guide for nurses working with families who have mentally retarded children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1964. 10 pp. 15 cents.

Set up in chart form, this guide provides suggestions to help public health nurses assess the nutritional needs of retarded children and their families; and to assist families with prescribed dietary treatment and with the introduction of techniques to help the retarded child achieve feeding independence. Feeding techniques are illustrated.

ILLNESS AMONG CHILDREN. Clara G. Schiffer and Eleanor P. Hunt. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 405. 1963. 107 pp. 35 cents.

An analysis of data collected by the National Health Survey on illnesses among school-age children, obtained in household interviews during the periods from July 1957–June 1958, July 1958–June 1960, and July 1959–June 1961. (See CHILDREN, July–August 1963, p. 160.) An appendix contains sources of information and 50 tables.

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SEPTEMBER • OCTOBER 1964

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Use of Drugs in Child Psychiatry

A River Trip for Delinquent Boys

Helping Neighbors Work Together

Case Report—A Child and Surgery

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children ®

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◀

ALONE AND TROUBLED, this child seems to sense the social isolation which so often aggravates the problems of mentally retarded children. Helping the mentally retarded child and his parents to break through such isolation and make the most of his potentials challenges the skill of a variety of professions. How work with the mentally retarded can transform the abstract concepts of social work into vivid realities for social work students is described in the article beginning on page 189.

A pediatrician as well as a psychiatrist, **Dr. Leon Eisenberg**, has been on the staff of Johns Hopkins Hospital since 1954, and has held his university professorship since 1961. He is a member of the U.S. National Committee on Vital and Health Statistics, editor of the *American Journal of Orthopsychiatry*, and editorial board member of other psychiatric journals. From 1958 to 1964 he was consultant to Baltimore City Hospital.

Paul W. Keve (left) has a master's degree in social work from the College of William and Mary. He has been director of Minneapolis' Department of Court Services since 1952. **John J. Fallon** (right), with an MSW in social work from Tulane, worked for the Hennepin County Department of Court Services as group program director from 1959 to 1963. He is now with the Community Health and Welfare Council of Hennepin County, Inc.

An active volunteer worker in welfare organizations for nearly 40 years, **Corrinne S. Tsanoff** is a past president of the National Federation of Settlements and Neighborhood Centers as well as of the Houston (Tex.) Settlement Association Board. In 1961 she received the Federation's "Outstanding Achievement Award." She is author of the book "Neighborhood Doorways," published in 1958.

Except for 2 years of social work practice with the U.S. Public Health Service, **Harold A. Richman** has been studying social work since his graduation from Harvard in 1959. He received his master's degree from the University of Chicago School of Social Service Administration and is now working at the same school for his doctorate.

With an MSW from the Columbia University School of Social Work, **Winifred E. Smith** concentrated on staff development in family casework until she joined the faculty of UCLA's School of Social Work in 1960. Since then her prime interest has been in field instruction in work with the retarded. She instructs students placed in the Child Development Clinic of the Los Angeles Childrens Hospital.

David Fanshel has been a full-time teacher of research at the Columbia University School of Social Work since 1961. For 5 years he was the research director of the Child Welfare League of America. He has done much research in foster care and adoption and is the author of many social work research monographs and articles.

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ROLE OF DRUGS IN TREATING DISTURBED CHILDREN

LEON EISENBERG, M.D.

Professor of Child Psychiatry,
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FEW TOPICS of discussion generate more heat and less light than the proper role of drugs in treating disturbed children. At one extreme are those physicians who argue that meaningful treatment is possible only by using the insights provided by psychotherapy—that drugs, if they function as more than placebos, do so only as chemical strait jackets for troublesome children—and that their use serves to delay recognition of the real psychopathology in the family. At the other extreme are those physicians who consider drugs *the* agents of choice because drugs attack disturbed function at the physiologic level, the place at which they believe the ultimate pathology lies. Partisans of this viewpoint usually also deride psychotherapy as an insubstantial metaphysical occupation, hardly worthy of the honorable calling of a physician. The controversy engages the passions of psychologists, social workers, and teachers, as well as parents. The first law of psychopharmacology might be formulated to state: the certainty with which convictions are held tends to vary inversely with the depth of the knowledge on which they are based.

There is as yet no universal and completely validated theory of human behavior that would permit a confident prediction of the utility of drugs. Even if we had such a theory the final decision would remain an empirical one. If an agent works well, then a physician, whatever his theoretical persuasion, will be a fool not to use it. For an empiricist, the relevant question becomes: What are the facts?

Experimental Principles

First, it is necessary to consider how the "facts" are obtained. If we wish to know whether aspirin lowers fever we need first of all accurate thermometers to measure fever. Then, we need a group of febrile patients to study. Next, since we know that fever is usually a transitory rather than a permanent condition, we need an experimental design that permits us to discriminate between a drug effect and a "natural" return of the patient's temperature to normal levels. This might be accomplished by having matched groups of patients, one treated by aspirin and one untreated, or perhaps one treated by aspirin and one treated by a second drug. But hold! What does the word "matched" mean in this context?

We know before we start the experiment that the fevers of a cold, of pneumonia, or malignancy, and of brain injury differ from one another in their mechanisms, duration, and susceptibility to modification. Furthermore, the course of the same disease differs in young and older patients; also, if other treatments are administered, these may influence the course of the fever.

Thus, a proper experimental design will require that the control and experimental patient groups be equivalent on those variables known to influence the phenomenon under study: in this case, the variables include diagnosis, age, other treatments, and

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The work reported in this paper was supported in part by a grant (MY-2583) from the National Institute of Mental Health.

other factors such as severity of condition and duration of illness. Moreover, we have to assume that other variables not known at the time of the study may be important. Since we cannot match patients on unknown factors, we attempt to take this into account by the random assignment of patients to one or the other group.

With these elementary conditions fulfilled, we must now include a sufficiently large and representative sample of patients to permit the meaning of any obtained differences between groups to be subjected to statistical analyses. These are simply mathematical procedures that enable us to determine how often the observed difference might be likely to arise by chance alone.

Again, the word "representative" requires attention. If we are to have any confidence that our treatment is useful for certain diseases, then we need to be reasonably sure that our sample is representative of patients with the diseases under study. For example, if they were all adults, we would not know whether the findings would hold true for children—indeed, for aspirin we would get quite different results.

Perhaps this simple model will illustrate the ingredients of a well-planned drug study: specification of the phenomenon to be studied; accurate instruments to measure the phenomenon; control for subject variables likely to influence outcome; random assignment to treatment groups; numbers sufficient to permit statistical analysis of findings; and a representative study population.

Effects of Expectation

But we have thus far not considered a major element in drug studies particularly relevant in psychopharmacology—the psychological effect of administering medication upon both the patient and the physician. We have all had the experience, when ill, of beginning to feel better once the doctor arrived, even before treatment began. Countless studies have demonstrated, both with objective signs (blood pressure, heart rate, skin lesions, and so forth) as well as with subjective symptoms (depression, anxiety, pain), that the *expectation* of a beneficial effect is often in itself sufficient to cause striking improvement.

When the medication is given to a child, it may influence him psychologically in one of two ways or both: (1) directly through his own expectations; (2) indirectly through altered parental behavior generated by anticipation of change in the child. Also, the physician or technician who judges the response may read into it results in keeping with the expected outcome. This is not "cheating"; the bias is usually outside the observer's awareness. Consequently, special precautions are necessary to keep from the patient *and* the doctor knowledge of the medication the patient is taking. This is done by giving a placebo, an inert substance made to resemble closely the active drug. The record of which patient is getting the drug and which the placebo is kept coded and is not revealed until all results have been scored. Such an experiment is termed "double blind."

Problems in Psychopharmacology

Evaluating the published data from drug studies in children is a complex task.[1] Consider first the question of the accuracy of the instruments for measuring the behavioral aberrations of our patients. In lieu of a "psychiatric thermometer" with known validity (correspondence of readings with actual temperature) and reliability (margin of error for repeated readings by different observers), we are restricted to such techniques as: evaluating mothers' reports of symptoms, observing the child, getting information from schoolteachers, using psychological test data, and fitting the data patterns into clinical judgments.

Changes in the mother's report may reflect actual changes in the child's behavior *or* changes in her perception of the same behavior; we cannot easily distinguish between the two. Observations of the child in the clinic may be limited in usefulness by the fact that children often behave atypically during the clinic interview. Teachers' reports, though valuable, are nonetheless subject to limitations. The child may not exhibit the target symptom in the classroom; the teacher's judgments are likely to include elements different from the clinician's; the teacher is herself vulnerable to "halo effects" because she knows the child is receiving help. Many standard psychological tests have not been designed to be sensitive to change over short periods. Somehow the clinician must combine these disparate elements into an overall judgment that he hopes will be a valid appraisal of the child's condition at the end of the trial. One can, with proper precautions, come to reasonable conclusions. At the least, however, pronouncements of finality do not seem warranted.

Our difficulties are no less severe when we come to controlling relevant variables. We can, of course, specify age, sex, and social class—all likely to influence outcome. But when we turn to so crucial an

Table I

TREATMENT RESULTS

Treatment	Improvement Rating			Total
	Marked	Mild	None	
Placebo	14	5	6	25
Meprobamate	9	10	5	24
Prochlorperazine	7	11	10	28
Totals	30	26	21	77

item as diagnosis, we are in trouble. No completely acceptable system is available for classifying children's psychiatric disorders. Some investigators try to bypass this problem by focusing on symptoms, selecting patients at random, and hoping that chance will have placed equivalent patients in the several treatment groups. When one considers how different schizophrenias, phobic neuroses, personality disorders, and adjustment reactions are in severity and prognosis, this would seem an idle hope. Diagnostic heterogeneity increases the likelihood of what statisticians term a "type II error": falsely concluding that no difference exists between treated and untreated groups. Many of the psychopharmacologic studies reported in the literature either give no indication of the disorder treated or lump together highly disparate conditions.

The remaining requirements can be met: random assignment, numbers large enough for statistical analysis, representative study population, and double-blind design. The fact that they are often *not* met reflects on the investigators rather than on the inherent limitations of current knowledge. It is dismaying that so many clinical reports state that a given drug is "highly effective" in the treatment of behavior disorders because of a 50- or even 70-percent improvement rate when no placebo group was included. The fact is that like improvement rates can be obtained from inert placebos because of (a) the physician's impact on the family; (b) the positive expectations aroused by treatment; and (c) physician bias in favor of improvement. Indeed, so strong is this physician and placebo effect in certain disorders that a drug would have to have rather extraordinary power to demonstrate conclusive superiority over the comparison placebo group. Useful drugs may be discarded because the requirements for showing effectiveness are so stringent. But, then, if a physician using an inert drug or his own personality can get good results, why expose the patient to possible toxicity and to the cost of new drugs?

These general considerations can best be illustrated by citing some problems encountered in studies at our clinic. In one study we assigned psychiatric outpatients randomly, on a double-blind design, to one of three treatment courses: meprobamate, prochlorperazine, both tranquilizers, and a placebo. All patients received concomitant brief psychotherapy. Although we did not match for age, IQ, sex, color, or social class, we did inspect our results to be sure that outcome had not been influenced significantly by disparity in these variables.

The children were rated at the end of the 7-week treatment period on the basis of mothers' reports, teachers' reports, and clinical observations. They were rated as markedly improved, mildly improved, or unimproved. A good correspondence between mothers' and teachers' estimates of improvement in the children gave us some confidence in the reliability of these evaluations, but we cannot be sure of their validity since we had no independent measures of behavior with which to compare them. The distributions of ratings for each treatment condition are shown in Table I. There is no evidence of benefit attributable to either of the active drugs—if anything, there is an appearance of superiority for the placebo.

The major finding of this study emerged in another direction.[2] Since there were no reliable differences attributable to type of treatment, we examined the improvement rates for each major diagnostic category, disregarding the specific treatment given. The outcome distributions are reported in Table II. The differences related to diagnosis are highly significant

Table II

OUTCOME IN RELATION TO DIAGNOSIS

Diagnosis	Improvement Rating			Total
	Marked	Mild	None	
Neurotic	15	6	0	21
Hyperkinetic	14	9	10	33
Defective	0	9	4	13
Antisocial	1	2	7	10
Totals	30	26	21	77

Table III

OUTCOME IN RELATION TO DIAGNOSIS

(Three Studies Combined)

Diagnosis	Improvement Rating			Total
	Marked	Mild	None	
Neurotic	48	17	6	71
Hyperkinetic	24	22	25	71
Totals	72	39	31	142

(probability of occurring by chance is less than 1 in 50). Diagnosis obviously has a major effect on clinical outcome. Had we ignored it and by chance assigned more neurotic children to either drug, the patient group on that drug would have enjoyed so good an outcome that we would have been led to regard that drug as a potent therapeutic agent.

Just how powerful and consistent these effects have been can be seen in Table III which summarizes the results of three outpatient studies (in none of which have tranquilizing drug effects been evident). The likelihood of this difference arising by chance alone is less than 1 in 1,000. Thus, these two categories of patients behave as if they were two distinct populations and must be dealt with quite differently. If we examine the improvement ratings for the neurotic children (54 percent showing marked and 91 percent at least mild improvement), it is evident that a drug will have to be remarkably effective to show a reliable superiority over placebo. This is why we have concentrated subsequent drug research on the hyperkinetic group whose treatment by placebo and brief psychotherapy is rather unsatisfactory.

A word of caution is necessary at this point. The studies thus far discussed have focused on *outpatients* (usually less seriously disturbed than children in residential treatment) and have included simultaneous, albeit brief, *psychotherapy*. Any generalizations from them must bear these essential factors in mind. Studies by others have shown that tranquilizers *can* be effective in the treatment of hospitalized children, at least in managing disturbed ward behavior. Possibly, in the treatment of neurotic outpatients tranquilizers might be useful in a situation where no attempt is made at psychotherapy. Review of the literature fails to reveal studies properly done to validate this possibility.

However, even if such evidence could be obtained, the reader should bear in mind that the psychotherapy included in our treatment schema consisted of five half-hour sessions, hardly an impractical amount for most settings in which children are treated. *All* drugs have toxic effects, some of which may not be evident until after long experience with them. Therefore, there would seem to be a strong argument for psychological management as the preferential treatment for neurotic disorders in pediatric outpatients.

Other studies at our clinic have focused on patient groups with a limited response to conventional treatment and have shifted to stimulant rather than tranquilizing drugs. A further experiment with a phenothiazine tranquilizer (perphenazine) on institutionalized delinquents once again demonstrated marked placebo effects (both by houseparent ratings of behavior and by improvement in the problem of bedwetting) but no detectable evidence of drug action other than unacceptable toxicity.[3] When we returned to the same institution for delinquents but employed dextroamphetamine, a stimulant, we obtained clear evidence of improved behavior in the adolescents on the drug.[4] The betterment was evident on two measures: symptom scores as rated independently by houseparents and by teachers, and sociograms, in which the patients rated each other. The verification of each measure by evidence of like effects on the other increases confidence in the results. Those on dextroamphetamine were significantly superior to those on placebo and to those in the control group. Placebo and control did not differ from one another.

This study, it must be pointed out, was limited to behavior in the institution. We would not anticipate maintenance of improvement once these delinquent youngsters returned to the same pathologic environment that spawned their behavior. The one toxic effect noted was weight loss (average 6 pounds) on the rather large dosages (40 milligrams per day) employed in the experiment. Clinical adjustment of dosage should enable the benefits to be obtained without such depression of appetite. Psychomotor excitement was not reported for any of the subjects, obviously an age-related result since excitement would be anticipated in adults. In a subsequent outpatient study, dextroamphetamine proved to be an effective drug in treating hyperkinetic children without producing excessive toxicity.

We have extended these studies to include a second stimulating drug, methylphenidate. Hyperkinetic brain-damaged children, mostly retarded, were placed on a rotating treatment schedule in which they received methylphenidate, phenobarbital, and placebo by turns. The most striking result was a prompt deterioration of behavior in the children on phenobarbital; methylphenidate showed a significant superiority over placebo, though either was clearly better than phenobarbital. In a second study,[5] employing methylphenidate and placebo, we evaluated symptomatic response as well as psychological test performance in disturbed children in a residential treatment center. Once again, methylphenidate produced a statistically significant diminution in symptoms when contrasted with placebo.

In addition to measuring symptom scores, we examined the children's performance on Porteus Mazes which test both intelligence and impulsivity, for they require planning before drawing a pencil line through a labyrinth. The children were given individual IQ tests and then divided into three IQ ranges (low=65–79; mid=80–91; high=94–135). Half of the children in each IQ range were given methylphenidate, half placebo.

The results for the entire patient group demonstrate significant superiority of performance (less impulsivity) by those receiving methylphenidate. Examination of the three IQ ranges separately reveals that the effect is due to enhancement of performance among the children in the two lower IQ ranges. Among the youngsters of normal or superior test intelligence, no drug effects were obtained. Several learning measures were also employed in this study. There were suggestions of improvement in learning in the children on methylphenidate, but the results were equivocal.

Diagnostic Categories

This brief excursion into problems of methodology indicates that the "facts" so cavalierly called for at the outset of this article are not so readily obtained, nor so completely reliable as we might wish. Yet drugs are being used in general medical practice to an extent that attests to the persuasiveness of advertising methods and to the weary search by physicians for a ready solution to the overwhelming burden of psychiatric disorders among their patients. Let us now consider what is known about the usefulness of drugs in relation to diagnosis and type of drug, and then propose general principles of treatment.

Children with *psychotic disorders* do not respond as dramatically to the currently available drugs as adult patients may. Nonetheless, the phenothiazine tranquilizers can be quite useful in checking destructive and impulsive behavior, thus rendering the child more accessible to educational and psychiatric management. Dosage must be adjusted on a highly individualized basis in order to obtain maximum benefit without a great penalty in impaired intellectual acuity. The more the psychotic symptom pattern resembles typical adult patterns, the more likely phenothiazines will reverse an acute psychotic episode.

Neurotic disorders seem rarely to respond in decisive fashion to available medications, though drug trial may be justified when symptoms are overwhelming. Then, phenobarbital, because of low cost and limited toxicity, should be tried first. Diphenhydramine, an antihistamine, is a second drug worth exploration. Psychological management is the preferred modality of treatment.

The merits of drug therapy for *personality disorders* are uncertain. Stimulant drugs may have a role in treating aggressive and impulsive patterns. If anticonvulsants have a place, it is limited to cases with electroencephalographic abnormalities. Phenothiazines may be worth trying.

The basic intellectual limitation in *mental deficiency* as well as the underlying pathologic lesions in *chronic brain syndromes* are not modifiable by any known medications. But hyperkinesis and distractibility, the most disturbing symptoms in these patients, frequently can be relieved by stimulants such as dextroamphetamine or methylphenidate.[4–6] About 10 to 20 percent of these patients are unresponsive to stimulants or may actually deteriorate when they are used. For cases with focal EEG abnormalities, anticonvulsants are indicated; in the remaining cases, diphenhydramine or phenothiazines may be employed. Barbiturates are almost always contraindicated except for the control of an associated clinical epilepsy.

Adjustment reactions rarely justify drug use, except for sedation in cases of acute anxiety following physical or emotional shock. These syndromes are related to environmental stress, and the physician should try to alter the family environment rather than drug the child, whose symptoms are a response to family pathology. Drugs may be more properly administered in treating the parents.

Classes of Drugs

For our purposes, the drugs used to modify behavior may be classified into tranquilizers, stimulants, and antidepressants; the tranquilizers may be further subdivided by potency and chemical structure. Mild tranquilizers and sedatives will be treated as a single class of drugs, in view of the lack of evidence that the mild tranquilizers produce less drowsiness or have greater effectiveness than the more traditional sedatives.[7]

Major Tranquilizers. The most potent tranquilizers are the ***phenothiazines,*** beginning with the familiar, extensively used, chlorpromazine. Phenothiazines can produce jaundice, extrapyramidal syndromes, and blood dyscrasias; they potentiate the effect of simultaneously administered barbiturates. When a phenothiazine is indicated in the treatment of a major psychiatric disturbance, the drug to be preferred with children is chlorpromazine because of its wider margin of safety for extrapyramidal manifestations. Prochlorperazine and perphenazine should be used quite cautiously with children because of the frequency of such alarming syndromes as painful torticollis (wryneck), trismus (lockjaw), and extrapyramidal seizures. ***Phenothiazines are powerful drugs and should be employed only when clearly indicated and with proper caution.***

The same strictures apply to ***reserpine*** and its derivatives, which have indications and limitations similar to the phenothiazines but, because of unpredictability, should be reserved for cases which have failed on phenothiazine.

Mild Tranquilizers. ***Diphenylmethane derivatives,*** such as hydroxyzine and diphenylhydramine, are mild tranquilizers. They have been used to treat behavior disorders, anxiety neuroses, and hyperkinetic syndromes.[8-10] Toxicity occurs less often than with the phenothiazines, but potency is also less.

Propanediol derivatives, such as mephenesin and meprobamate, are of limited utility save as mild sedatives. Habituation and tolerance to these agents have been reported in adults, but not in the doses used with children; acute toxicity has resulted from accidental ingestion of large amounts. There is as yet insufficient evidence to delineate the role of such new agents as chlordiazepoxide and diazbepam in treating children despite the enthusiastic claims accompanying early clinical trials. Both these drugs, as well as meprobamate, are described as having muscle relaxing properties useful in treating cerebral palsy and allied disorders. They may give rise to drowsiness, rashes, and withdrawal effects.

Sedatives. Sedatives, drugs that allay anxiety and excitement, have long been available to physicians. Most widely used are the ***barbiturates.*** Sedatives have proved of limited value in treating the psychoses and were largely supplanted by tranquilizers once the antipsychotic potency of phenothiazines and rauwolfa derivatives were recognized. Unfortunately, many physicians have assumed, despite the lack of evidence, a similar high index of effectiveness for tranquilizers in treating neurotic disorders. Comparative outpatient studies indicate similar results with drugs classified as tranquilizers and those termed sedatives. Phenobarbital, because of its inexpensiveness, low toxicity, and relative safety, is preferred for psychoneuroses to the more exotic tranquilizers.

Stimulants. Stimulants, such as ***dextroamphetamine*** and ***methylphenidate,*** have their greatest usefulness in the treatment of the overactive and distractible child. Toxicity, manifested chiefly by anorexia and insomnia, can usually be controlled by modification of dosage. Prolonged medication with these drugs can apparently be maintained without serious hazard, though it is well to discontinue treatment during the summer when the child's symptoms are less disruptive to organized activity. There is risk of addiction in adolescents who get a "kick" from them. Uncontrolled use may result in toxic psychoses.

Antidepressants. Antidepressants have little use in child psychiatry. Claims for ***imipramine*** in the treatment of enuresis were not borne out in a recent study. A study with iproniazid in autistic children was abandoned after the acute liver toxicity in adults was recognized.

Principles of Drug Treatment

Our observations have led us to the following principles:

1. ***Drugs can be useful agents in managing pediatric psychiatric disorders when chosen appropriately and applied with discrimination.*** They can control symptoms not readily managed by other means and can facilitate psychotherapy by allaying symptoms that disrupt learning. If they are not the panaceas portrayed in advertisements, neither are they the poisons claimed by their foes.

2. ***Skill in using drugs requires knowledge of their pharmacologic properties and sensitivity to their psychologic significance.***[9, 10] Every drug study reveals the potency of placebo effects—benefits occurring from relationship with physician and from positive expectations of patients. These effects can be used to potentiate pharmacologic results by recognizing that the prescription of medication is an important

communication to the patient and his family; contrariwise, they can have a negative impact if the physician regards drugs solely as weapons to impose control or as measures of desperation.

3. *No drug should be employed without firm indications for its use, without careful control of the patient, and without due precautions against toxicity.* With any potent drug toxicity is inevitable; to justify its use the severity of the condition and the likelihood of benefit must outweigh the possible toxicity. Toxicity studies on adults cannot be safely extrapolated to children because of differences in the immature and developing organism; clinical decisions must be based on data from pediatric studies.

4. *An old drug is to be preferred to a new drug unless evidence of superiority for the latter is clear.* This principle of pharmacologic conservatism is based upon the fact that unexpected toxicity from a new agent may be apparent only after prolonged experience with it. This is not pharmacologic nihilism. Drugs can make a decisive difference in treatment, but their very potency commends us not to use them lightly.

5. *Drugs should be used no longer than necessary.* Dosage should be reduced periodically, with the goal of ending treatment if symptoms do not return on lower dosage.

6. *Dosage must be individualized.* Each person is metabolically unique. Undertreatment as well as overtreatment can result in erroneous conclusions about unsuitability of a particular medication for a particular patient.

7. *The use of drugs does not relieve physician of responsibility for seeking to identify and eliminate the factors causing or aggravating the psychiatric disorder. All* currently available psychopharmacologic agents treat symptoms not diseases. Symptomatic relief is not to be disparaged. But to prescribe drugs for a child whose symptoms stem from correctable social, familial, biological, or psychological disturbance without attempting to alter the factors causing the symptoms is a disservice to the child.

There is no assumption here that psychotherapy is necessarily any more of a specific than drug therapy. It, too, has symptomatic and nonspecific effects; exacting proof of its efficiency remains to be provided. It, too, can act as an anodyne if not accompanied by searching efforts to correct the untoward life stresses acting upon the youngster. The justification for psychotherapy appears to lie in its possibilities for modifying learned unhealthy behavior patterns. However, the patient may become accessible to psychotherapy only after the acuteness of his symptoms has been diminished by pharmacologic methods. It should be emphasized that control of symptoms by drugs is not an end in itself; symptom control provides a climate in which the patient can learn new and more effective patterns for coping with his environment.

Drugs have a definite but limited role in the treatment of disturbed behavior. Medical evaluation of new drugs seems to follow a time sequence characterized by: early enthusiasm, growing criticism and awareness of toxicity, premature calls for discard, and final sobriety with moderate agreement on indications and dangers. Drugs are neither the passport to a brave new world nor the gateway to hell. With thoughtful selection, careful regulation of dosage, and close scrutiny for toxicity, they add a significant element to a total plan of patient care.

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[1] Fisher, S.: Child research in psychopharmacology. Charles C Thomas, Springfield, Ill. 1959.

[2] Cytryn, L. et al.: The effectiveness of tranquilizing drugs plus supportive psychotherapy in treating behavior disorders of children: a double-blind study of 80 outpatients. *American Journal of Orthopsychiatry,* January 1960.

[3] Molling, P. A. et al.: Committed delinquent boys. *AMA Archives of General Psychiatry,* July 1962.

[4] Eisenberg, L. et al.: A psychopharmacologic experiment in a training school for delinquent boys: methods, problems, findings. *American Journal of Orthopsychiatry,* April 1963.

[5] Conners, C. K.; Eisenberg, L.: The effects of methylphenidate on symptomatology and learning in disturbed children. *American Journal of Psychiatry,* November 1963.

[6] Laufer, M. W.; Denhof, E.: Hyperkinetic behavior syndrome in children. *Journal of Pediatrics,* April 1957.

[7] Laties, V. G.; Weiss, B.: A critical review of the efficacy of meprobamate in the treatment of anxiety. *Journal of Chronic Diseases,* June 1958.

[8] Freedman, A. M.: Drug therapy in behavior disorders. *Pediatric Clinics of North America,* August 1958.

[9] Fish, B.: Drug theory in child psychiatry: psychological aspects. *Comprehensive Psychiatry,* February 1960.

[10] ———: Drug therapy in child psychiatry: pharmacological aspects. *Comprehensive Psychiatry,* August 1960.

SENDING THEM DOWN THE RIVER

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ON A BRIGHT morning in early June 1961, a heavy raft, pushed by two outboard motors, moved out into the Mississippi from the University of Minnesota campus and started down the river's main channel toward New Orleans, 1,764 miles ahead. The raft was a homemade affair, with a wooden deck as big as an average parlor floor, and that deck was loaded with sleeping bags, footlockers, cans of water, gasoline and oil, boxes full of food and, most important, 15 boys and 4 adults—the first adventurers in what was to become an annual river project sponsored by the Hennepin County Juvenile Court (Minneapolis, Minn.).

The boys had put all their optimism into just one word on the unprofessionally lettered sign that carried the craft's name, the "Unsinkable." To them the voyage was sheer adventure. To the staff and social agencies in back of the Unsinkable the voyage represented a serious experiment in therapy.

The idea of the voyage came from the boys themselves, but the atmosphere conducive to its birth and growth was provided by a group treatment effort known as the "Weekend Ranch Program." This program began in 1959, when the Minneapolis Post of the Volunteers of America offered the use of its Bar-None Ranch to the District Court's Department of Court Services, which provides probation services to the Juvenile Court. The ranch, with its 700 acres, was about 30 miles from town.

The plan which evolved was for a group of about 30 to 40 boys aged 12 to 14 needing intensive help to be selected from the probation caseload and given a group living-and-treatment experience every weekend. The age group was specified in order to provide a homogeneous group of children young enough to react with some enthusiasm to the ranch. The program's purpose was to keep the boys out of an institution by giving both them and their parents the help they needed.

The plan was to include some of the more seriously delinquent children from the probation caseload, excluding those handicapped by gross physical defects or unusually low IQ. Children would be selected who were markedly hostile and distrustful of adults, who had severe difficulties in getting along with their parents, and whose parents were especially inadequate. They would be children who were achieving far below their capacities in school and giving their teachers constant trouble. In short, they would be the children within the defined age group most likely soon to be on their way to a training school.

On the basis of these criteria the probation officers were asked to suggest candidates for the weekend program. One probation officer was made director of the program. He discussed the appropriateness of each candidate with the referring probation officer.

At this point all that was lacking was money—for the salaries of two or three part-time student workers, for transporting the children to and from the ranch, for feeding and bedding them for each weekend.

Fortunately, several businessmen in the community were interested in the two agencies and in the problem of juvenile delinquency. Drawn into the planning, they responded with pledges to support the evolving program for a 3-year experimental period, and to serve as an informal advisory committee to the project. The element that particularly drew their interest was the proposed effort to work with both child and parents without removing the child from the home except for the 2 days of each weekend.

Each boy selected came into the weekend program for an indefinite period—from a few weeks up to a year and a half, or more—depending on the benefits he was receiving. The boys initially approached the weekend ranching with caution or even reluctance, since it was presented as a part of their probation plan. Parents too were indifferent. The plan was put to them in a juvenile court hearing where the judge made it emphatically clear that he expected both boy and parents to participate in the program. If the parents had strong reasons for objecting, the boy was not required to take part, but once they agreed to it they and the boy were expected to participate fully.

Every Friday after school a bus picked up the boys at arranged meeting points and got them to the ranch by suppertime. From then until Sunday afternoon their time was filled with a variety of assigned chores interspersed with a greater variety of recreational activities. All the usual housekeeping jobs had to be done, plus the farm chores. But for these city boys the program offered new kinds of fun with even the grubbiest jobs. Disposing of the garbage meant hitching two ponies to a cart and driving off through the woods to the dump. Cleaning the dairy barn meant a chance to romp in the hay afterward. There were horses to be cared for too, but this meant the excitement of horseback riding at other times.

All the boys had fun but all were boys with problems, and each showed his problems in his own special way. There were vicious temper outbursts. A boy would try to bully and dominate the group. Another boy would be markedly withdrawn, afraid either to fight or to play. One would steal from the others, while still another would proffer endless gifts of candy bars in an effort to obtain friends. More problems would appear at bedtime—bedwetting, masturbation, nightmares. The advanced schizoid condition of one boy became evident when he persisted in sleeping with a box over his head.

We soon saw that the weekend living experience had excellent diagnostic value. Under ordinary circumstances a probation officer could not get to know his charges as intimately as the Weekend Ranch Program staff learned to know these boys in the intensive 48-hour living situation each weekend. The boys' problems were revealed starkly in that close society.

However, since our main purpose was treatment, we used the diagnostic insights almost the moment they came in treatment efforts. The most specific treatment device was the Saturday night group discussion period, a free-ranging talkfest in which the staff leader participated just enough to keep the talk going in the most introspective directions. The boys criticized each other with gusto and raised questions of any kind that bothered them. They had usually observed enough behavior problems in the group that day to give them plenty of discussion material. The leader encouraged them to ask themselves why they behaved as they did and what better ways of solving problems there might be.

Parent Discussion Groups

The parents had their own discussion groups on Sunday afternoons. They were divided into two groups, each group meeting every other Sunday. Each parent was expected to drive out to the ranch for at least six of these sessions. This requirement was tactfully but aggressively enforced even if the staff had to pick up and transport car-less parents to the ranch or otherwise circumvent the parents' excuses. Most of the parents came to these sessions reluctantly at first. Some may have been afraid of being lectured to or otherwise having their weaknesses held up to view; or they may have looked on the trip as a nuisance interfering with other Sunday plans. For some it meant the annoying necessity of staying sober for the day. But just as most of the boys became enthusiastic after a taste of the ranch life, most of the parents relaxed after a few sessions and seemed to get satisfaction from them.

These parents were accustomed to failure and to feeling blamed for their children's problems. Therefore, their initial conduct in the sessions was either a cautious reserve or a projecting defensiveness. Evidence of a growing satisfaction came gradually. Little by little they tended to talk more freely, to approach closer to a look at their own involvement in their children's problems instead of placing the blame elsewhere, and to exhibit a cautious willingness to see whether they themselves might make some personal change that would make things better for their sons. Some even showed up on the in-between Sundays when they were not required to come.

Always the group leader remained unobtrusive and let the parents find their own topics as they sat around a table supplied with coffee and cookies.

We regard these parents' group discussions as a highly essential part of the whole treatment effort. Whether or not the experience effected change on the parents' part, it at least kept the parents keenly aware of what we were doing with their boys and helped to win their support. It gave us a better entree into the total family life than we usually have.

Birth of an Idea

Since the weekend schedule was closely tied to the school week, we had to look forward to what could be done in the summer when the boys would be more available. During the first summer we began by conducting normal camp activities. However, on the third week we took all the boys on a 40-mile hike to an encampment in a State park, an activity which was to bring about a major new direction in the summer program. Several boys, thought to be ready for release from the program, on the hike exhibited their old problems: shop-lifting, stealing, general disrespect of property, difficulty in meeting adults or even other children. For the first time, problems could be seen and dealt with as they occurred.

As a result we planned another trip which would give the boys more involvement in community life and activity with staff control and guidance available. This was a canoe trip to the remote Canadian border country, planned to include frequent stops along the way—to fix meals, go sightseeing, hike at scenic spots, and to do necessary shopping. These stops were deliberately planned to provide the boys with contacts with other people. Before the trip staff and boys spent considerable time discussing attitudes toward stealing and property rights and ways of getting along with people.

The immediate result was a wonderful trip. The long-range result was the new program idea—the use of trips as a framework for treatment.

During the following year when summer plans were being discussed with the boys, several ideas for trips were considered. The boys' final choice was to build a raft and make a trip down the Mississippi. The planning for it began about 6 months ahead of the second summer vacation. The plan was for all 30 boys in the Weekend Ranch Program to be involved in the river trip; half would travel on the downstream trip and the other 15 would go to New Orleans by bus and ride the raft on its return trip upstream. However, we had a few things to learn.

The plan was popular with the boys but not with everyone else. For a probation worker to float down the river all the summer with a bunch of boys is not the conventional way of doing probation work. Some people wondered whether the trip would not seem to be a reward instead of a proper punishment for delinquency. Some assumed that it would be just a lark. The idea and the reasons behind it had to be discussed thoroughly with the authorities before it could be assured of the essential official support.

The Department of Court Services is administered by the District Court of Hennepin County, which has the freedom to permit and support any kind of treatment program that its judges regard as being a proper function of a probation service. Because of the unconventionality of a river trip as a probation method, the judges were initially somewhat skeptical of the proposal. Therefore, several persons with long experience in YMCA or other social group work programs were asked to meet with some of the judges and the probation staff to discuss it. After numerous questions had been asked and all apprehensions aired, they agreed that the idea was sound enough to justify a trial, and the court gave its assent.

In planning the trip we were looking at certain severely handicapping characteristics typical of the boys in this program. They were from families with narrow horizons who seldom took trips or even talked about things that went on elsewhere in the country or the world. They knew little about any geography beyond their own neighborhoods or of historical and cultural differences elsewhere. Their families had few goals for them, educational or otherwise. The boys had no motivation to stay in or do well in school for they had no notion that anything being taught them would have practical use in their lives.

The river trip provided a way to attack such deficiencies. Boys who never planned ahead for more than a few hours were for the first time engaged in sustained planning for an event that was 6 months away—an event exciting enough to catch their imagination and hold their attention through all that time. Boys who scorned arithmetic in school found themselves struggling willingly with numbers as they computed the buoyancy of an oil barrel and went on from there to determine how much weight the total raft would sustain and so how much gasoline could be taken along, plus food, sleeping bags, and people.

Boys who never had given a thought to the world beyond their own neighborhoods and had rejected geography in the classroom found themselves studying maps to pick the towns along the way where stops would have to be made for fuel, food, and water. Next they wrote letters to the mayors of these towns to find out whether they had docking facilities and whether gasoline and other supplies would be available—for the first time using their school lessons in how to write a proper letter. When the answers to their letters began to come in, boys who had always felt rejected by people in authority had the heady experience of being welcomed by the mayors of town after town and assured that they would be greeted and served on their arrival.

Meanwhile the raft was being built and the boys worked on its construction every weekend. Forty borrowed oil drums were arranged in four rows to serve as pontoons. Lumber donated from Army surplus was worked into a platform over the pontoons. One boy who had consistently failed in school stood before the group one evening and competently explained how he had computed the number of square feet of surface for each oil barrel to determine how much paint would be needed to cover them all.

Since an endeavor such as this inevitably raises visions of possible accidents, illnesses, and even drownings, we discussed problems of liability with our county attorney. He informed us that we were in a fully defensible position if the trip was in the hands of competent staff; if the parents were fully advised of the venture and freely consenting; if the boys had prior instruction in all appropriate safety measures; and if all the desirable safety precautions were taken on the trip. Meeting these conditions presented no problem. Representatives of the Army Corps of Engineers, the Coast Guard, and the Red Cross came to the ranch to speak to the boys on first aid, water safety, and navigation. Safety rules were then developed by the group: Life jackets were to be worn at all times on the water; no swimming was to be done except when the raft was tied up and after staff had designated a safe swimming area.

An insurance policy similar to the type usually available to camps gave us coverage in respect to accidents, illnesses, and other hazards.

Obtaining parental consent might have been a problem if there had been no parent discussion groups. These had given the parents ample opportunity to hear of the plans from the beginning and to ask the director whatever questions they had about any aspect, to make suggestions, or voice objections. As the time for the trip came near each parent was asked to give a signed consent, and the parents of all but one boy willingly did so. He did not go.

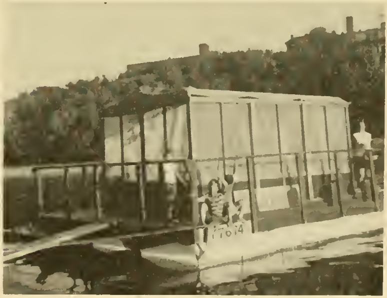
This process not only developed parental consent in a natural way, but in some cases it gave parents and boy a common interest that they had previously badly lacked. On the early morning that the Unsinkable finally began its voyage, nearly all the parents were on hand to see it off.

To live all day, every day with 15 boys on a deck measuring 16 by 33 feet is confining and could be nerve-racking. It was made tolerable by the immense variety of the passing scene. Every bend of the river brought a new vista and every day brought its quota of new wildlife to see, barge tows to wave at, locks to go through, fishing to be done. The boys themselves did nearly all the navigating, cooking, and cleaning up. The close living required an interdependence that was a good new experience for them and also had superb diagnostic value for the staff.

The treatment elements were of several kinds, some arising from the natural daily situations and some

Boys at the Bar-None Ranch constructing the Unsinkable.

The Unsinkable ready for the long voyage down the river.



contrived by the staff members on the raft. Some boys obtained real help from just being away from their homes in an exciting and satisfying living situation. Daily life with strong and likable adults was undoubtedly another helping factor. Certainly some of their new experiences also had a constructive effect. For example, coming into one town on the heels of a severe storm the boys found that many boats along the dock were being swamped and washed away, and they struggled energetically to help save them. The next day they found themselves described in the local paper as heroes. This and other experiences with admiring city officials all along the river gave them a taste of the pleasure of being recognized for constructive rather than destructive acts.

There were also negative experiences, usually a cropping up of old problems. In group discussions around the fire ashore in the evenings the staff exploited both positive and negative experiences.

Twenty-eight days after the pushoff from Minneapolis the boys were in the busy main channel of river traffic in New Orleans. After a few days of sightseeing in the town they returned home by bus.

According to the original plan, the second group of boys, having arrived by bus, started the return trip upstream on the raft. "Ol' Miss" was not so agreeable to this, and we found that our power was not equal to the job of getting the raft back in time for the start of school. So these boys completed the return trip by bus.

An Overview

The Weekend Ranch Program is now 4 years old and the river trip has been used in three of the four summers, including the 1964 season. Many modifications have been made as we have gained experience—including shortening the trip, with St. Louis as the destination—but the basic plan will be continued. Not everyone has a Mississippi River so nearby to go drifting on, but the essential idea of the tripping program is packed with treatment potential that might be utilized on various kinds of trips.

We naturally have wondered if the program could be expanded to involve a greater number of boys, for as it is it represents a heavy investment in staff time for a rather small group. We would like to see it expanded if expansion means having more group projects rather than just adding more boys to this project. Thirty boys is probably the largest number that can be handled successfully in one project and may be too large unless the selection process has been skillful. A larger group will threaten the control of group dynamics and exhaust available staff time.

The program director can spread himself only so thin. While most of the year his program is actually in process only 48 hours a week he has an immense amount of planning to do; he must spend time regularly each week in training his part-time assistants; and he must meet frequently with probation officers who want to refer new boys to the program or ask about boys already in it. Emergencies require time to be spent during the week with the boys' parents, or their teachers, or the boys themselves.

Expansion, in the sense of adding more such projects, should be feasible—if enough money and competent professional staff are available.

However, there would be no point in extending a replica of this program to many of the young people in a typical probation caseload. One reason for its effectiveness is that it has been designed to meet the needs of a narrowly defined group of children. If a number of group projects are to be instituted within one probation department, it would be better to have each one designed to serve a different type of child and to revolve around a different type of activity.

When we started the Weekend Ranch Program we were more concerned with an action project than with research, though we did want to evaluate our work as reliably as possible. We tried to develop a control group for comparison but encountered some insoluble problems in selecting the controls. We finally settled for an orderly process of subjectively evaluating each boy before, during, and after his involvement in the program, on the basis of school, court, and police records as well as personal observations by his probation officer and the program staff.

Among the 56 boys who were admitted to the Weekend Ranch Program in the first 2 years, 4 did not stay in the program long enough to be helped; they got into more trouble and were sent to institutions before the program could affect them.

Of the 42 boys who stayed with the program for 12 or more sessions, 33 seemed to improve. In some instances this was apparent in nothing more than a cessation or a substantial reduction of delinquent activity. In other cases it showed also in school behavior and academic progress. In six cases improvement was dramatic. In general the boys who were the most disturbed were the ones who seemed to make the most progress. Following the trip they showed some regression in adjustment but only a partial regression, with a satisfying net gain remaining.

Such gains support our faith in the value of combining therapy with adventure.

How the residents of a housing project in Houston have been roused into . . .

WORKING TOGETHER FOR NEIGHBORHOOD IMPROVEMENT

CORRINNE S. TSANOFF
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A BAFFLING and tantalizing problem for those who work in settlement and neighborhood centers is how to involve an entire low-income neighborhood in a large-scale effort to improve and develop itself. Experience shows that some people will participate in an improvement program, become leaders, take responsibility—but many more will remain anonymous, withdrawn, apathetic. For many persons, the procedures for getting the kind of service they need are too unpleasant to think about.

Five years ago, Neighborhood Centers Association of Houston and Harris County (Tex.) initiated an experimental action program in one such neighborhood. The program had two major objectives: (1) to see whether a whole neighborhood, with a trained staff to guide it, could become involved in a program to better itself and develop its own leadership; (2) to tell the residents of the city's special services and persuade them to use these services, not only in crisis but as part of a coordinated and continuing program. The planners had another hope: that through this program of self-help and development, the residents would get a better understanding of the meaning of the democratic process. Neighborhood Centers was already working in what it considered an ideal unit for such a program: Clayton Homes, a public housing project where parents were slow to enroll their children in school, delinquency was high, and dropping out of school was common.

Clayton Homes, built in 1952, has 348 families, about 1,500 persons, and was built on land reclaimed from a bad slum area. It is an isolated community—separated from any normal neighborhood by the Eastex Freeway and railroad tracks, by Buffalo Bayou, and by industrial warehouses. The nearest market is a mile away. The two-story buildings have yard space around them and there is a small playground at one end of the project. Just outside the playground fence, along the banks of the bayou, Houston industries used to dump their garbage.

The people who live here are Mexicans, some recent immigrants, others second generation. They have large families and many families have no father at home. They are unskilled workers with low incomes. Many of them are illiterate in Spanish and unable to speak English. There is a high incidence of sickness, disability, dependency, and family breakdown.

Neighborhood Centers had conducted a routine settlement program in Clayton Homes until 1959. Our staff, consisting of social group workers, expressed doubts about whether the residents could be roused into taking active interest in affairs outside their own families and their immediate needs. The first step, therefore, was the preparation of our staff through considerable discussion and seminars. The next was to drop membership requirements to participate in Neighborhood Centers.

Late in 1959, the staff was ready and we held a meeting to outline the plan to the people of Clayton Homes. They showed no resentment at the necessary surveys and the strange consultants. On the contrary, they seemed interested and pleased to know that others were really concerned about their well-being. They chose as a name for the program "Neighborhood Development" rather than "Neighborhood Improvement" because they felt it expressed a more constructive attitude. "Improvement" seemed to imply that something was wrong with them.

Getting Under Way

The staff decided on three self-help projects in an attempt to interest everyone: a Christmas festival, a cleanup of the project grounds, and a kindergarten readiness program. The community was divided into six sections, each with a leader, and a committee of the leaders was set up.

The festival was the first project because Christmas was close. In previous years the several hundred dollars contributed by the Clayton family at Christmas bought gifts for the children. But for Christmas 1959, the committee used the money to buy and sack fruit. On Christmas Eve they took a sack to the door of each family with a recipe for fruit salad, wished everyone a Merry Christmas and invited all to join their section's procession to the recreation building for the Christmas program. Each procession had its Madonna, and the Madonna of the largest procession was to be the Madonna of the crèche. The smooth execution of the Christmas program gave everyone a glimpse of the possibility of working together.

Other projects followed, at first proposed by the staff, and later by the residents themselves: deroaching apartments, getting Houston's sanitation department to eradicate the rat menace, protesting the dumping of refuse at their fence. Without total cooperation, these cleanup campaigns could not have been effective. They were effective, and they are now annual projects.

Group spirit increased. The sections decided to elect leadership committees annually and a committee chairman every 4 months. This was disturbing at first for persons accustomed to be leaders in every project, but its value in uncovering potentialities among residents is constantly demonstrated. At first only women were interested, but now seven men hold offices and many more are active in projects. Increasingly, the Neighborhood Centers' staff has let the suggestions come from the residents themselves.

The community next took on the problem of education. Every family in Clayton Homes with a child of kindergarten or first-grade age was visited by a committee member or a staff person who explained the requirements for enrolling in public school and the advantages of regular attendance. The committee held a reception and invited the principal and school nurse of the elementary school and the mothers of the children who would attend the school. Both principal and nurse spoke effectively on the advantages of a child being ready to enter school on the first day. As a result of these talks, every child had his shots and vaccination and was at school with his mother to enroll on opening day. The school has participated in similar kindergarten readiness programs held at the housing project for the past 4 years and in its two neighborhood art exhibits. The principal has also met with small groups to discuss differences in education in Mexico and the United States; how parents can help children study; effective discipline; what school achievement can be expected of children at different ages; the influence of home on school achievement; and the value of education to the child.

From their concern with their children's education, the parents turned to themselves. For 3 years, two evenings a week, they have been taking night classes in English and citizenship courses at a public high school. The home-management committee has sponsored cooking and sewing classes for women and girls.

Last year the committee put up outside Christmas decorations for the entire housing project. Several persons had warned that teenagers would tear them down, but many others had replied: "Not if we put them up." Not one decoration was destroyed. A washateria, built by fiesta funds and outside contributions, and a limited grocery store are managed by residents under direction of Neighborhood Centers.

Thus, the people of Clayton Homes grew in self-confidence and understanding as they came to grips with many problems that had formerly overwhelmed them. Where necessary, the staff members provided guidance to make workable projects out of suggestions.

The Problem of Teenagers

The attitudes and behavior of the teenagers were a grave concern to their parents and the community. A new program to win their participation in neighborhood improvement was needed. In June 1962, as part of the Sabin polio vaccine campaign, the chairman of each adult section recruited two teenagers from his section. Together they attended a meeting to plan the participation of teenagers in the campaign. The youngsters adopted the sectional organization of the adults and elected officers. They recruited other teenagers to work at section headquarters. They arranged for a special bus to take teenagers to the vaccination center. Ninety-seven percent of the youth of Clayton Homes were vaccinated.

After this flying start, the youth leadership committee decided to sponsor parties, dances, and field trips. To train them for leadership responsibilities, the Neighborhood Centers' staff took them to an out-of-town camp for a 2-day retreat. There the staff explored the youngsters' needs, interests, and attitudes. The youngsters said they wondered what their neighborhood friends would think of them and whether they would participate in the plan. They expressed a need for activities outside of school "because we hardly ever get a chance to take part in special activities in school." But they realized they needed to learn how to work in community programs. They also pointed to the need for activities for boys and girls who are always in trouble "because they need attention."

After some get-acquainted activities, the teenagers organized a skating party, theater party, and a dance. In March 1963, they held their first election for a leadership committee. Of 162 teenagers, ages 14–19, in Clayton Homes, 151 voted. The elected leaders went on a 2-day retreat to become acquainted with their new responsibilities. They had training sessions during the first 6 weeks in office.

From the adult and youth leadership committees a Neighborhood Council to deal with policies and activities of the whole community was formed.

In the summer of 1963, the youth committee and the staff, working together, arranged for a preemployment and work training program for boys and girls. Adapted to the young people's inclinations and abilities, the program included typing, filing, work with cars, kitchen and janitor service, baby sitting, and home economics. The participants were rewarded by trips to interesting places all over Texas. To earn money for these trips, the girls won agreement from several construction firms in Houston to let them clean up newly built apartment houses. They did this in teams. The response of Clayton Homes' youth to this program was especially gratifying because other agencies involved with them doubted its chances of success.

Service to neighbors is also emphasized in the teenagers' program; some of them have even "adopted" elderly residents who need their help.

Coordination of Services

When the neighborhood experiment began, over 32 special agencies were in and out of Clayton Homes on more or less emergency requests. Their services were not coordinated; indeed, many agencies did not know the others were present. And too often the services were poorly understood or accepted by the people who needed them most.

As the second phase of our experiment, we sought acceptance by all agencies of an integrated program so that their services could be understood, desired, and requested before the agencies offered them. Neighborhood Centers took on the responsibility of developing this understanding and acceptance. This proposal was to apply particularly to new services rather than to the established and known services.

To win support for the program, the director and assistant director of Neighborhood Centers Association visited the leaders of each agency they thought might be interested in helping the development of Clayton Homes. In April 1962, an administrative commission, representing the boards of all interested agencies, was set up under the chairmanship of a board member of Neighborhood Centers Association. This commission sees that the program's policies do not conflict with their agencies' policies, advises on how the agencies could best contribute to the program, and follows up suggestions.

The Neighborhood Council of Clayton Homes, with staff help, suggests activities it would like to see included in the program and submits them to the administrative commission and to the city board of Neighborhood Centers for approval.

There is also an administrative advisory committee, made up of agency executives, to keep the agencies in touch with the needs of the community and its progress, a technical committee of supervisors of agencies with workers in the project, and an operating committee of all staff personnel working in the neighborhood. Also, volunteers with skills in vocational employment counseling, law, homemaking, counseling and education in family life, leisure time activities, and in mental and physical health problems were invited to participate.

After 4 years of intensive work in neighborhood development, we see leadership developed in Clayton

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Homes to an extent that surprises even the staff. The residents have learned of their abilities to confront and to solve many of their problems—and this has increased initiative and self-reliance. Their ability to work together has nurtured community spirit. Unmet needs have been uncovered and special services established to care for them.

The juvenile court probation officer and the police department's juvenile division report a noticeable reduction in unsocial behavior. Children are enrolled in school promptly. The school reports better general attendance than in previous years. There has been a noticeable change in parental attitude toward education. The director of the city housing authority maintains that the entire atmosphere of Clayton Homes has improved markedly. "The people were cold and unfriendly toward each other. Now they know each other and work well together. Vandalism has noticeably lessened."

The cochairman of an adult leadership committee has said that when he moved into Clayton Homes 3 years ago he knew no one. He attended a general meeting and became interested in working with boys. He has now signed up 16 other fathers to sponsor scout troops. Five boys were such troublemakers that the fathers wanted them kept out. "But I told them," the cochairman said, "they are our boys and we must get hold of them. Three of the five now belong and no longer are troublesome."

Of course, problems remain: incomes are still low, families are still large, family breakdown occurs. As in any community, personalities sometimes clash, and status means a great deal. Some committee members have resisted broadening the base from which leaders arise; they enjoy their status and hope to retain their elected positions. We regard this problem as arising from human traits rather than failures of method. But we ask: Can neighborhood development overcome both the unwillingness to assume responsibility and the desire to retain too much responsibility? Can we keep committees from stagnating without stimulation from the staff? How much responsibility can a neighborhood leader be expected to carry? Most of the residents, especially the men, work long hours and have little time or energy for community affairs.

We have derived much information from our project and are now ready to introduce the techniques and tools used in Clayton Homes into comparable neighborhoods within our larger district of operation. We shall use Clayton Homes as a laboratory training center for developing "multipurpose" professional staff for working in integrated service projects and developing indigenous leadership in these other communities. We shall also count on help from Clayton residents, who are often able and willing to report their neighborhood's progress.

We share a serious difficulty with every participating agency—lack of operating staff trained for this type of neighborhood development procedure. In the past, social workers have been educated to identify the problems, recognized by our own standards, and to offer solutions. But in our work the staff must first listen before they talk. Centralized agencies with highly trained staff find it difficult to adapt themselves to this level of operation.

New Outlook Needed

People in deprived neighborhoods need help when their emergencies occur. They find it difficult or impossible to make appointments a week or more ahead to talk over difficulties which may no longer be in their focus of attention, though they may be lurking in the background with bad effects. Filling questionnaires is an insuperable obstacle to the illiterate person. Many poor people distrust the person across the desk; they leave an office bewildered and never return.

Centralized agencies are willing to send workers into a neighborhood for specified hours for consultation—but the idea of establishing services with which residents can identify and which they can use in emergencies seems difficult for them to accept. Should agencies require that the client be trained to accept their services, or should they train workers to offer services on a neighborhood level where people can and will accept them? If our health, family welfare, and recreation agencies intend to help the most deprived part of our population, our minority groups, they must unlearn some techniques and devise new ones for listening to, interpreting, and meeting the needs of these people. Until this is done, a great obstacle to helping deprived persons will remain.

Every social agency wants to help, but footing it out in a neighborhood is more tiring than the desk interview, and even settlement workers, trained for neighborhood service, often wear out in the process. Somehow our specialized social work procedures must find a new outlook—perhaps area services established by and recognized in the neighborhoods they serve, with staff members close to the people and recognized as friends. Such centers could represent several agencies.

An old settlement byword says: "The people who need you, need you near." The need is pressing.

CASEWORK WITH A CHILD FOLLOWING HEART SURGERY

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IN A ROOM on the cardiac surgical service of a large research hospital, an 8-year-old boy was engaged in a physical and emotional struggle for life. His name was Tim and he was afraid. As Tim's social worker, I was concerned with his fear, a fear that remained even beyond the immediate physical crisis. As his health slowly began to return, I tried to help this weakened boy wrestle with his fears and nightmares.

The emotional needs of young children during hospitalization are usually met through the security and understanding of the parent-child relationship. Therefore, casework efforts are usually concentrated on helping parents handle their feelings and attitudes so they can be most helpful to their child. Occasionally, however, parents become so overwhelmed or have such a distorted relationship with their child that they are unable to sustain him and direct casework with the child becomes necessary. Such was the case with Tim.

His home broken by his mother's divorce from a psychotic father, Tim lived with two younger siblings and a narcissistic, masochistic mother, herself the product of a disturbed home and ineffectual parents. She appeared to court crisis and disorganization in the family and in her own life and to reject Tim.

During Tim's most critical days his mother was demanding and unsupportive, and Tim reacted by withdrawal and depression. Failure of attempts to help her with her relationship with her son, and the extent of Tim's critical emotional needs, made me decide to work directly with him.

Tim was suspicious of strangers. Many new consulting doctors had been seeing him to control postoperative complications; their visits often signaled new and frightening treatments. When I introduced myself as a social worker who wanted to talk to him, Tim said he had just had another heart operation and did not like all the needles he was getting. For several days we talked about his treatments and his family and played some games. On the fourth day I suggested that we form a club to meet, talk, and play together regularly. Tim said he would like that. When I asked him what we should name the club, he answered, "The Two Men Club"—a tangible expression of his need and readiness for a special relationship. I soon turned my office into our clubroom and, whenever possible, wheeled Tim from the ward to our room.

I hoped to achieve several purposes: to learn how the hospital experience was affecting Tim so I could help him master it, for now and the future; to be a patient, understanding person unconnected with his treatments and medicine, to whom he could talk about his daily ups and downs and thus to help him to accept and benefit from his difficult medical regimen. The club would be a place where he could assert his independence, make decisions rather than simply obey them, talk about new things, have new experiences, and be encouraged, within the hospital limitations, to exercise a boy's natural curiosity. Finally, I hoped our relationship would provide Tim with confidence to express his feelings and give him the experience of having a healthy male relationship.

The Early Sessions

During our first few meetings, we made clay club badges for ourselves and signs and decorations for the club room. Tim participated eagerly as far as his meager energy allowed. However, he was protective of his thoughts and feelings and quickly changed the subject any time I mentioned his illness. I began to tell stories about an imaginary Robby Robin who fell from his nest. When I asked Tim what happened then, he said that Robby's mother called the doctor. I asked whether Robby was hurt and had to go to the hospital. Tim became tense and said emphatically, "No," Robby was not hurt at all. Several days later I asked if we should tell a story about a boy instead of a robin, and he replied softly, but firmly, "Not about me."

I did not want to push Tim. We played games, finger painted, and visited the gift shop, the patients' library, and the room with the experimental animals. He responded eagerly to these new experiences, but in his creative play, his art work, and his relationship with me (except for constant complaints about shots) he was restrained and rejected any reference to his own thoughts or experiences. In our play with a doctor's kit, he refused to find anything wrong with the doll patient and would not give shots or medication.

During the second week, while we were finger painting, Tim said very quietly that he could not fall asleep the night before. (The nurses had told me Tim was sleeping fitfully and had a troubled expression on his face while asleep.) When I asked him why, he looked away for a moment and then said easily that he was worried about his roommate who had had a seizure several days before. We had discussed this frightening experience before in a special club meeting I had called the night it happened, so I did not think this was Tim's real worry. But I did not press him.

Over the next week our relationship deepened. We talked more about his troubled sleep and the "worries" that kept him awake, but he could not get himself to tell me what was worrying him. We made two evening trips to the roof to view a newly launched weather satellite. I gave Tim a picture postcard I brought back after a 2-day absence. He kept it inside his shirt. He continued to reach out for new experiences and became more relaxed and spontaneous in our club play.

A turning point came at the beginning of our third week as Tim pointedly tested our relationship. I mentioned the possibility that he might go home in 2 weeks. He did not respond to this. Instead, he told me that several other patients had asked to join our club. I told him that this was the "Two Men Club" and that our membership was full. I repeated what I had told him many times: I was his social worker and the club was for us to talk and do things together. He seemed relieved, then asked what would happen to the club when he went home. I told him that I might be able to visit him there. He seemed very pleased and said, "Maybe we can find a cabin or a little home where the 'Two Men Club' can meet all alone." During this period he checked my whereabouts constantly. I recognized his need to test me before he could go further with our relationship, so I responded to his demands as much as I could.

A New Emphasis

On the following day we began 10 days of club meetings very different from those of the previous 3 weeks. The emphasis turned from play to talk, a switch Tim himself initiated. During the previous 3 weeks we had used the dictaphone in my office, talking into it and playing it back. Occasionally, I told a story on it. Tim was a little hesitant to record his voice, but he enjoyed the playback. His recordings usually told what he had done the day before. On this day I asked Tim if he wanted to tell a story on a record. Since we had visited the animal room, I suggested it be about an animal. He told the following story:

> **Once upon a time there was a little mouse who did not have nobody to play with and nobody to love him. One day he went out for a walk into the far, far forest. A lot of animals were crying for help because the big elephant was chasing them. The little, little mouse grabbed the big, big elephant's tail and swung it around his head and threw him out of the jungle. He was the bravest mouse in the whole world, and he grew up to be a guinea pig.**

As we played the story back, Tim looked frightened and held his ears. When I told him we did not have to play it back, he insisted that he wanted to hear it. This was the first glimpse Tim had allowed me of the world in which he was struggling.

There followed three successive club meetings devoted to stories, all told at Tim's suggestion and all heard back with covered ears and frightened expression. They told of a world of fear, impotence, violence, and helplessness. These were the stories of the two succeeding days:

Once upon a time there was a little baby elephant named Panda. He took a walk in the forest where he came upon a big, big deer, and he said "Hello" to the deer, and the deer said, "Why, hello," and they were pals. They walked through the forest until they came to this beaver, and the beaver said, "You have a spear. I want a spear, but how do I get one?" "Here's one," cried the little beaver, so they started out for another walk, and they saw this hunter, and he had a gun, and he was going to shoot them. So they ran back and locked their doors and lived happily ever after.

* * *

Once upon a time there was a big dinosaur who thought he was going to die, and he said to himself, "I am going to die, I know it, I'm going to die." He walked through the forest and all the other animals were happy but he was the only one who was sad because he was sick.

On the following day we played back some of the old records. The last one told about Robby Robin falling out of his nest. Tim hastened to say that nothing at all had happened to Robby and that he needed neither doctor nor hospital. At this point I had to terminate the meeting and left Tim alone at his request to make a record on his own. This is the record:

Today when Tim and Mr. Richman had a meeting of the club, he could not stay long, so we made a couple of records and we listened to them, and after that he went home, I mean where he was going to go. He did not have much time so he got the record player and let me make a record while he was gone. So I did. I made a record and listened to it and I had so much fun that I could not bear to tell this and it was: Once upon a time there was this little robin named Robby Robin, and he set out in the far, far forest, and Robby did not like the animals. One day this great, great big hunter came and he was hunting a whole lot of birds and he killed Robby.

While I recognized the great significance of these stories for Tim, I chose not to discuss them with him. He was getting along well in the ward and club, and I saw the stories not as alarms but as Tim's own way of working out his anxiety about his illness and surgery, within the safe context of our relationship.

Several days later Tim indicated that he needed more direct help. Important visitors were at the hospital and Tim's surgeon was going to speak to them about new advances in heart surgery. Five postoperative children were brought to the solarium to meet the visitors before the surgeon's talk. I saw Tim about an hour after the visitors left and he appeared rather dejected. When I asked how the morning had gone, he replied, "OK," but he had not been allowed to hear the surgeon's talk. When I asked about his interest in the talk, he became very tense, said he did not want to talk any more, and mumbled something about "what he used." Later that afternoon I saw Tim on the unit and he asked me where I was going after work. He had never done this before, but he would not tell me why he wanted to know. I gave him my telephone number and told him he could call me if he needed me.

The next day I suggested that we talk about the operation. He was reluctant, but I pressed him a little, telling him that I thought I could help him. Then I asked several direct questions: Had he been scared of the operation? Did it still frighten him? Was he worried about it? To each question he answered in a small voice, "Yes," and began to look frightened. Tears began to roll down his cheeks, but he was not sobbing, and he looked at me as though he wanted me to go on. I said I knew it was hard for him to think about it, but that if we talked about it a little more he might feel better. Then I asked if he could tell me what it was about the operation that he found so scary. The tears continued and he struggled for several minutes before he could whisper, "The knife." This admission brought on real crying for several minutes. When he was calmer I asked Tim to describe the knife. He drew, hesitantly, a picture of a large curved knife with a sharp toothed edge.

When I asked how long he thought it was, he held his hands about 2 feet apart. When I asked what about the knife worried him, he replied, "What they do with it." I asked when he thought about it, and he said, "All the time." When was it the worst? He said, "At night, when I dream about it." Still crying quietly, he told me about the dream that came every night: A huge figure chasing him, wielding an enormous knife. Did other things frighten him? Tim looked at the floor and asked if the blood clots he coughed up were pieces of his heart.

As he used up his meager energy crying out some of his fears, Tim came close to me and held my arm. I held him for a few minutes, told him I knew that his fears were real and painful, and reassured him about the size of the knife (really only 4 inches) and the coughing. I could not reassure him that he would not have to undergo the knife again; instead, I emphasized his great progress over the last 3 weeks. No words or gestures, however, could really soothe the starkness of his terror. I hoped that my presence and our mutual trust would lighten the burden of his fears.

During the next days the nurse reported that Tim's sleeping seemed less disturbed, and 3 days later Tim told me he had not had the knife nightmare. Later he reported that the nightmare recurred the night before he left the hospital.

Three days after our interview about the knife, the doctors decided that Tim could go home the following week and report weekly to our outpatient clinic. He would, however, have to remain quiet and be watched closely.

Tim was reluctant even to talk about going home, so I began the following story. At certain points I stopped and asked him to take over.

Worker: Once upon a time there was a frog. His name was Fog, Fog the Frog. And Fog the Frog lived in a bog. And Fog the Frog who lived in a bog liked to sit in the mud, and he croaked in the mud. He went: Glug, glug, glug. And one day the people from the hospital saw Fog the Frog in the bog and they said: "We think we should take Fog the Frog out of the bog and bring him to the hospital." So they asked Fog the Frog whether he would leave the bog and come with them. He said—

Tim: "Yes."

Worker: So they took Fog the Frog out of the bog and brought him to the hospital—

Tim: and the hospital took science research on him, just any kind of research—

Worker: and he sat in his little glass house on the seventh floor in the animal room and he went glug, glug, glug. And he thought about where he was, and this is what he thought.

Tim: He didn't like it in the animal room very much—

Worker: and the little mouse who was his nextdoor neighbor said to the frog, "Why don't you like it at the hospital here in the animal room?" And the frog said—

Tim: "I don't have any water."

Worker: Fog the Frog belongs in the bog. But he stayed here for a while, and finally there came a time when he just decided that it was time to go back to the bog, but he didn't know if he wanted to go back to the bog or not because—

Tim: his friend, the mouse, was his nextdoor neighbor—

Worker: and they liked each other, and he couldn't decide whether to go home to the bog or to stay at the hospital. And he thought and thought and he decided—

Tim: to stay at the hospital with his friend the little mouse.

In view of Tim's ambivalence about going home and his investment in our relationship, I decided to continue seeing him during the transition period. Tim's mother had first asked for this plan and she cooperated fully. The time factor and hospital policy dictated that this arrangement could be only temporary. We agreed on a maximum of 12 months.

I visited Tim the day after he went home and then at biweekly intervals for 2 weeks and weekly thereafter. His physical condition continued to improve and with TV and toys he was keeping himself amused. Our interviews centered on his daily activities and did not deal with any new issues. Since Tim was a child who responded eagerly to new experiences and opportunities, I sought community resources which could help him lead as active a life as he could physically handle. At the same time I was paving the way toward ending my own work with him.

The first priority for Tim was school. He was already a year behind, and for future social as well as academic reasons I was anxious that he not fall further behind. A teacher from the county board of education began concentrated first-grade instruction at his home. A warm, cheerful woman, her thrice-weekly visits provided a new, engaging relationship for him. In addition, an occupational therapist from the county tuberculosis and heart association visited Tim once a week, leaving craft projects and new games which delighted him. He was soon busy making little gifts for everyone he could think of, including a carefully stitched leather key case for me.

The Caseworker Withdraws

Tim's physical condition improved rapidly. With the early spring weather he was soon outside making friends with the neighbors and playing in the yard. Since he would probably be well enough to go to public school in the fall, I thought it would be helpful for him to have a group experience with normal children beforehand. After a long search, I finally found an excellent day camp for healthy children which would accept him. Located on the grounds of a private school, the camp emphasized crafts, nature study, and sports. Our doctors endorsed Tim's attendance, and the camp director was carefully informed of the boy's limitations and special needs. Our faith in Tim's emotional stability and ability to adjust was wholly vindicated at camp. He fitted into the group beautifully and achieved poise and satisfaction. Visiting one afternoon at Tim's invitation, I saw him try to keep up with his friends in a swimming race. He got tired and a little blue, pulled himself out of the pool, and obviously unhappy, slowly dried himself in a far corner. After a while he came over to me with a smile and led me to the arts and crafts shop to show off the wastebasket he had made for me.

School began, and I visited Tim at home twice in the first month. He was in the second grade and doing well. He got along well with his classmates, but during the first 3 months he had to be helped to limit his outdoor activity to his physical capabilities. Therefore, I visited the school to talk with the principal about Tim's physical condition. Tim knew about my visit and was pleased.

As Tim associated more with healthy children, it became apparent that he felt more and more pressed to keep up with their activities. Eight-year-old boys place a high premium on activity and Tim was not able to keep up. For his own self-confidence and social development he needed to find some areas in which he could achieve and excel. I arranged for him to join a small Cub Scout troop, where he could develop his interest in scouting skills and nature lore. He responded enthusiastically and gradually became less frustrated at his limitations in the schoolyard.

Ten months after Tim had left the hospital, he and I agreed, both reluctantly, that we would not get together except when he came for a clinic visit. At this time, I arranged with the Big Brothers of America to provide him with a Big Brother. The Big Brother selected was a family man with a farm outside the city and a strong interest in nature study and outdoor life—an excellent person to provide Tim with the male companionship, identification, and understanding that he now needed so much more on the personal than the professional level.

Three months after my last visit to Tim's house he came into the clinic. His heart was still not well, but he had lost some of the pasty look of a chronically ill child. As we finished a game of darts in my office, he bent over the dictaphone and asked if he could make a record. I was surprised because I thought that our records held bad memories for him. I gave him a blank disc. He hesitated, then asked if he could tell a story alone. I told him I would wait outside. Five minutes later he opened the door and beckoned, then began to play the record he had just made. From the dictaphone came a clear, confident voice—not the hesitant, frightened voice of a year ago.

I have a friend who is Mr. Richman. This is a story about him. Once I had a friend named Mr. Richman. He was a good friend. One day I was going to the store and I met him. I had a bag of popcorn and it was all falling out, so he helped me, and we got home fine. Then when we got home, he ate lunch with us, and then he went home.

The end.

Then Tim picked out an old record at random and played part of it. When he came to the description of the mouse who was so frightened, he smiled and said, "That was me." Impressed with the contrast between Tim on this day and the day he left the hospital, I asked him if he remembered our story about Fog the Frog. When he said he did, I reminded him that we never really knew what happened to Fog, and suggested that we finish the story just for fun.

Worker: This is the second story about Fog the Frog, who used to live in the bog. Fog came out of the bog when the people from the hospital came and brought him here, and he stayed here for a while in the animal room until it was time for him to go back to the bog. So Fog the Frog went back to the bog and now we want to find out what happened when he got back to the bog.

Tim: When Fog the Frog got back to the bog he went on his lily pad. Since he wasn't near his lily pad, it was all soaked up because of the rain, but Fog the Frog who lived in the bog got out a new one. It was a brand new one.

Worker: And he sat on his lily pad and he went glug, glug, glug, which in frog language means—

Tim: thank you and all the people at the hospital for helping me.

Worker: And the people at the hospital said they never had a nicer frog than Fog who came from the bog.

Discussion

The extent to which I could help Tim depended upon our developing a relationship of trust. His naming of the "Two Men Club" indicated the possibility of his readiness to use a close male relationship. Because such a relationship was new to him, many sessions studded with long awkward silences were required to nurture it. During these sessions play proved to be invaluable as a way to establish rapport.

Considering his background and the intensity of his feelings, Tim's hesitancy to reveal himself was understandable. Even within the safety of an increasingly trusting relationship, Tim found it difficult to express his most troubled feelings—of impotence, helplessness, and fear. In his fantasy world of animals and the jungle he found a medium for expressing them symbolically. However, he feared too much to risk expressing these feelings directly to me, even in fantasy language. Here, the dictaphone played the pivotal role; it could not reject him. That the stories he told were really meant for me was unmistakable from Tim's own behavior in insisting that I play the records back and then covering his ears in fright. Only after the fantasy had been woven and spoken through the impersonal dictaphone and had been heard, understood, and not rebuffed by me could Tim begin to express his fears directly, as he did about the nightmare and the knife.

I chose an indirect approach in handling the material presented in Tim's stories. I allowed him to tell them without interruption. After carefully listening to the playback, I would make a quiet, general comment about the central theme (fear, death, helplessness) without tying it to Tim or his situation. I always followed this comment with a direct reassurance to Tim that he was doing well and getting better, thus responding to the underlying feelings of doubt and uncertainty which he was expressing through the stories.

I chose this approach rather than direct interpretation for several reasons. The mere process of making and listening to the records and having me there seemed to decrease some of Tim's general anxiety. He was becoming more relaxed with me and his behavior on the unit and during sleep was less agitated. Also, I had the feeling as he watched me listening to the playback that he felt I understood what he was trying to say. In addition, the content of the stories seemed to progress in intensity and closeness to reality, indicating that Tim was moving on his own toward a more direct expression of his feelings.

Had Tim appeared more disturbed with me, at play or when asleep, I would have considered either stopping the recording or beginning some direct interpretation, using the story material as a bridge to discussion of his real anxieties. This course would have required consultation and guidance from the psychiatrist and would have required enough time on my part and enough energy on Tim's to deal with the uncovering of deep anxieties.

One of the difficult decisions associated with our relationship was my continuing to see Tim after he left the hospital. Ordinarily, discharged patients who need continued service are referred to an appropriate community agency. Tim's discharge, however, came rather abruptly and at the time of his most intense relationship with me. A break then would have meant a rejection of his hard-won ability to use help. More time was needed to prepare Tim for the termination of our contacts and for the gradual encouragement of his ability to develop other relationships with people in the community who could help him. While our final separation was difficult, it came only after Tim had integrated much of his experience with me, and after the integration had been tested and proved in his use of the community resources provided for him.

The foregoing points describe the conduct and rationale of the work, but they do not touch the heart of the treatment. This was the elemental process of responding to a weakened, struggling child's need for love, strength, and understanding. Tim's sobering words and fears deepened my respect for the impact of critical illness and surgery on children. His growth during the period of our relationship heightened my appreciation of the potential of direct, limited-focused casework treatment in helping sick children.

Tim's future is uncertain. His heart is too damaged to carry him very far and soon he will face another life-threatening operation. I am hopeful that he will be able to approach this experience with increased emotional strength and capacity.

And so we move into the age of space. What mental equipment shall we carry with us on this leap into the unknown? What shall be our credentials as citizens of the brave new world? Shall we go as Neanderthal men, weighted down with suspicions, fears, and hatreds of our Adamic ancestors, or shall we go as men and women, erect and unafraid, recognizing every other man and woman on this now tiny orb as full and equal partners in the most fundamental and enduring of all enterprises? That enterprise is to develop human capacities for good to the ultimate limit of their potential.

Whitney M. Young, Jr., Executive Director of the National Urban League, at a conference of the League.

SERVICE TO THE RETARDED AS SOCIAL WORK EDUCATION

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A PARADOX of service to the mentally retarded is that while this field has been long distinguished by the participation of many professional disciplines, the professional education of the practitioners has almost uniformly failed to include relevant content. Whether pediatrician, psychiatrist, educator, psychologist, public health nurse, or social worker—the professional has usually acquired his knowledge and skills in mental retardation essentially through postgraduate practice.

This state of affairs cannot continue if we are to meet the challenge of mental retardation in terms either of numbers or qualifications of the professionals required. Nor can we continue to demand that the institutions and agencies serving the mentally retarded bear the major responsibility of providing their practitioners with the special expertise needed for effective service. Obviously, each of the professional schools concerned must assess and modify its curriculum to meet this challenge.

The problem of how to include content specific to mental retardation in an already overcrowded curriculum is not unique to social work. But "curriculum space" is not the only problem the schools of social work face. If they are to fulfill their obligation to produce in this period of accelerated social change a professional person capable of effective service in the many and varied problem areas already defined—not to mention those yet to emerge—the schools must resist those forces encouraging fragmentation and restrictive specialization. As specialized content is considered for addition to the curriculum, it must be evaluated with reference to what it displaces. But, more importantly, it must be examined to determine its ultimate contribution to the common core of knowledge, skills, and values which constitute the essence of social work practice in any field. Learning experiences that best further this overall goal are most certain to be included and kept in the curriculum.

This article will examine the validity of social work field instruction in agencies serving the mentally retarded as sound preparation for social work practice in general. Its thesis is that student experience gained in study and service to the mentally retarded child and his family not only helps insure inclusion of content relevant to this crucial problem in the social work curriculum but also meets the highest standard of social work education by the enrichment and extension of the total educational experience.

It is often said that the field of mental retardation is too highly specialized to meet the learning needs of social work students. In view of the commitment to generic social work training permeating social work education today, this contention cannot be ignored. The issue of generic *versus* specific in social work education is a legitimate one that commands critical attention.

Obviously the generic-specific issue should not be an either-or controversy. There is no such thing as a generic agency, a generic client, or a generic service. Yet each instance of social work activity occurs in the context of professional social work practice and is a definite and concrete manifestation of its responsibilities, its perception and definition of problems, its body of knowledge, its prescriptions of action and techniques for intervention, and its value perspective. The social work student must learn how to know, how to see, and how to respond as a social worker in situations where he is called upon to perform as a professional.

In a generalized sense every social agency worthy of the name offers the opportunity to contribute to this process of becoming a social worker. But for the purposes of social work education this is not enough. To determine whether the field of mental retardation is effective for the development of this identity and capacity, we need to inquire further into the range, visibility, complexity, and saliency of the learning experiences it provides.

As the Student Sees It

Crucial to the attainment in social work practice is the process of selective discrimination. The student coming to the field of service to the mentally retarded finds it difficult to perceive where this experience fits in with his becoming a skilled social worker. The condition of the retarded person looks so hopeless and final that he doubts that this is a proper area for meaningful social work intervention. Differential social diagnosis and subtle and creative treatment goals seem irrelevant and futile.

Initially, the simple fact of mental retardation is the only reality for the student. He concludes that attendant manifestations—illegitimacy, delinqency, or poverty—are attributable in a simple and final sense to low mentality. He does not readily see that mentally retarded persons have a growth potential, that the differences among them are real and significant, that they share the hopes and fears of all mankind, and that they and their families can use and desperately need the services of the social worker in ways that make crucial differences. But with experience, under the guidance of an informed field instructor, the student develops a growing capacity to discriminate those facets of the situation responsive to social work intervention.

In this process of discrimination, the student from the outset must come to grips with his lay preconceptions. This is a demanding and sometimes painful process. But students who have had this experience report, long afterwards, that this capacity to discriminate, as well as the conviction of the validity of social work gained through this experience, has served them well. I do not suggest that this is due to the shock effect of service to the mentally retarded. Rather, it is the product of the nature, range, and saliency of the learning experiences that make such an invaluable contribution to the development of social work skill and perspective.

Application of Theoretical Concepts

Mental retardation is a problem that cuts across class, ethnic, and religious lines. The social worker must be familiar with such factors and be able to assess and relate them to his social diagnosis and treatment goals. The problem strikes the individual, the family, and the community and demands solutions which resolve or mediate conflicting interests. It hits all age brackets. Thus, the social worker must know the needs and potentialities of each stage in man's life cycle.

The complexity of society and its highly institutional organization cannot be ignored by the social worker. Social work has reflected growing awareness of the importance of this perspective—an awareness documented in a heavier social science emphasis in the academic curriculum and a growing sophistication in discussions of social work issues and practice. Once the mark of distinction for the social worker was his ability to speak knowingly of the stages of psychosexual development, ego defenses, transference, and the like; today he must be equally conversant with such concepts as social role, socioeconomic class, power structure, social systems, and institutional networks. But for the practitioner, theory without the opportunity to apply and test its validity and relevance has limited significance. Therefore, increased attention is being directed to the student's field experience to provide vital and concrete meaning to these concepts. Here service to the mentally retarded offers a unique learning experience, particularly in understanding the individual's relation to society, its institutions, and the forces for social change.

For example, workers with the mentally retarded become quickly aware that the retarded person's self-image is determined inordinately by the way society views and values him. Because the focus on him is mostly negative he, and frequently his family, becomes the victim of social isolation with stressful consequences for all concerned. Furthermore, retarded persons have a special characteristic: Unlike others in our society, they experience excessive difficulty in having their needs met through the normal social institutions. Whether it be school, church, law, recreation, or work, each institution must adapt its program to the retarded person's special needs if he is to participate.

Today the professional literature is replete with the application of social role theory to problems in social work. If one wishes to bring to the student's attention the significance of social role as a factor in his diagnostic formulations, what better example is there than the parent of a retarded individual? The parent is called upon to fulfill the parental role throughout his lifespan with no regard for his changing capacity or needs—or for the conflicts and distortions this creates in his other roles and their demands on him in the successive phases of his life.

Few field experiences offer such a rich and varied potential for the student in the application of concepts and theories from the social sciences. In no other problem area does the individual's relation to his society and its institutions stand out in such sharp relief.

The family is an important part of the institutional framework as well as the primary unit of our society. In social work intervention, the family occupies a unique place. In mental retardation, the family is both the matrix for understanding the retarded person and, more often than not, the locus of the problem brought to the social worker's attention.

Family dynamics constitute a substantial segment of social work curriculum. Few settings equal those serving the mentally retarded in providing the student with opportunities to witness the strivings, vicissitudes, and dynamics of family life in all stages of development. The impact of the crisis and the chronicity of mental retardation involves all members of the immediate family, and its consequences may reverberate to the farthest reaches of the kinship structure.

There is little likelihood that workers schooled in service to the mentally retarded will lose their family-oriented perspective; intervention predicated on any other perspective would be an absurdity. Students trained in this area of service, regardless of their ultimate field of practice, are likely to reflect a family-focused orientation, both in assessing the determinants of behavior and in defining the problem to be solved.

The social work student is repeatedly taught that human behavior is biologically, psychologically, and socially determined. If this conception is not to remain an abstraction, he must test its validity and applicability in assessing his clients and their problems. This conception is inescapable in the field of mental retardation. It is not only essential to effective social work practice, but it also shapes the structure of the programs and the kind of professional personnel who serve the retarded. Working with other professions in a common effort, the social work student learns to appreciate the significance of the knowledge and expertise they bring to bear on situations in which he is immediately involved. He also learns to define his own professional role in interdisciplinary practice.

Basic Knowledge

Since social work is always practiced in relation to a particular problem area, the student needs much specific knowledge and information about the given problem *per se.* In addition, he must have the kind of knowledge which is the base of his activity as a social worker wherever he may practice. It is essential that he distinguish between these two bodies of knowledge, however intertwined they may become in application.

We do not wish to graduate students with the false assumption that they are prepared to work with any social problem in any setting without attention to its unique manifestations and characteristics. The highly identifiable and specialized body of knowledge pertaining to mental retardation which the student must acquire for effective practice in this field helps dispel this illusion; at the same time, it provides him with an understanding of a prime professional obligation—the necessity for the acquisition of particular knowledge relevant to his given area of practice, whatever it may be.

There are many opportunities in the settings serving the mentally retarded for the development of the student's basic practice skills. However, such settings have particular significance to one aspect of current developments in social work practice and education: The boundaries that once distinguished the various methods of practice are becoming blurred. We seem on the verge of a single social work method which for any individual social worker will, in varying degrees, encompass the skills of casework, group work, and community organization, and demand more than a passing knowledge of research, administration, and social policy.

Increasingly, the field of mental retardation is being used as a setting for training in social group work. The literature of mental retardation contains many reports of social work practice combining the methods of casework and group work in a creative synthesis. For the student in placement in a program for the retarded, his dependency on research is real and evident. The demand for new services for retarded persons makes the student a participant in vital community organization efforts, and in the administrative processes that translate policy into action. If the social work student working with the retarded does not become a whole professional person, it is not for want of opportunity.

All aspects of social work curriculum reflect concern with values, but in his field work the student has the opportunity to put the value commitments of his profession to the test. Here ethical dilemmas do not come prepackaged and labeled. The student must not only define the relevant issues but select the resolutions that are consistent with the values and philosophy of his profession. Only through such a process can his profession's values become his own.

I know of no setting superior to that of the agency serving the mentally retarded in the demands it makes of the social work student to declare where he stands. Perennial questions such as individual *versus* societal rights, the right of self-determination, the obligation of society to provide each of its members an opportunity to realize his maximum potential, the tyranny and cost of prejudice, and the individual's essential worth and dignity—all quickly move from the abstract to the concrete through manifestation in the lives of clients. In the field of mental retardation we do not have to stretch our imagination to find learning experiences involving questions of ethics and values; we cannot ignore them if we try.

The Role of Tragedy

One aspect of professional maturation has taken on new meaning and depth to me after working with students in the field of mental retardation—the stance of a social worker when confronted with the tragedies of life. Social work grew up in an era of optimistic belief in inevitable and ever-accelerating progress. There was even talk of the time when the need for social work would disappear. Many of us cherished the belief that we could not only cure the individual's ills and make him independent of us, but through our social action we could cure the ills of society.

The events of recent years and our developing maturity have tempered our initial optimism and demanded of us a new appraisal and orientation. The search for meaning and direction in these troubled times is not the student's alone. One of the deepest and truest motives that brings students to social work is related to this search, and it is the responsibility of social work educators to engage fully with them in this quest.

As a field teacher in the problem area of mental retardation, I have found two experiences deeply moving to my students. The first is coming to a realization of the essential tragedy of life. I refer to tragedy in the classical sense—each man must confront his aloneness as well as his relatedness, he must know suffering as well as joy, and he must die as well as live. But tragedy is not the same as pessimism, for in this confrontation with reality lies a release and freedom, hope rather than despair. The ordeal through which the student achieves this wisdom is not an easy one. Indeed, there are many who never attain it. But if it is not realized in training through service to the mentally retarded and their families, it is not the fault of the placement. Here the student learns that all cases do not have a happy ending, all ills do not have a cure, and that often he must settle for the limited goal and find satisfaction in doing his best to minimize losses.

Hard as this lesson is to learn and accept, there is still another to be learned. I recall the young student who had the responsibility of telling a middle-aged woman that the only child she would ever bear was severely defective. He listened to her recite the hopes and dreams she had cherished for herself and the child, hopes and dreams that now could never be. He learned to stand with her in despair, share the burden of her grief, and still offer realistic hope; it was a tremendous accomplishment.

But an even more difficult and important lesson was that, although he could stand beside her, there would remain one sector of her suffering that he could not enter or do anything about. No matter how far along the way he went, in the end she must stand alone with her grief. That he could know this truth, that he could realize that this was his ultimate fate, too, gave a new dimension to the meaning of acceptance, a dimension that would forever be his.

To recognize and accept the tragic aspects of life is a liberating rather than a constricting viewpoint that admits realistic, not false, hope. The student who has been privileged to witness the themes of tragedy and hope in the lives of the retarded and their families will have come a long way in his quest to realize himself professionally as well as personally.

An essay review . . .

AN UPSURGE OF INTEREST IN ADOPTION

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IT has been estimated that there are some 1.5 million adopted children in this country at the present time. In 1962 alone, courts in this country granted adoption petitions for about 121,000 children, 52 percent of them being adopted by persons not related to them.[1] Thus a substantial number of children and their families are directly affected by the institution of adoption.

Nevertheless, there have been very few attempts by social workers or other students of the family to develop any basic formulations about the adoptive family as one variant of this fundamental human institution in our society. Examination of the professional literature could easily lead to the conclusion that adoptive families are essentially the same as families whose children are theirs by birth.

The attempt to develop major theoretical perspectives about the adoptive family, seen from its unique characteristics, has had to wait until the appearance of the book, "Shared Fate," by H. David Kirk.* This is a provocative piece of work based upon a decade of research involving a number of projects which brought the author into contact with 2.000 families with adopted children. The theory spun out by the author will prove fascinating not only for readers interested in adoption but also for those who are enthusiastic supporters of theory-building in the behavioral sciences and social sciences.

Adoption has come to be viewed as a highly valuable resource of society. Much of the professional and lay literature about it tends to contain overt or tacit enthusiasm about what it has to offer deprived children and infertile couples. If there has been any intellectual soul-searching by professional persons concerned with this basic welfare service, it has been around such concerns as reducing the amount of time children spend in foster care before going into adoptive homes, finding adoptive parents for categories of children for whom this resource is not generally available—Negro children, physically handicapped children, older children—or focusing attention upon antiquated State legislation which has stood in the way of early abrogation of the rights of parents who are grossly neglecting their children.

All of this interest has had as its focus the task of providing needy children with good adoptive families. What happens to these children *after* they have been placed and *after* the courts have granted the adoption has only recently been the object of investigation.

Perhaps it is natural for professional social workers not to concern themselves with the aftermath of adoption since, with a few exceptions, their contact with adoptive families normally ends when the adoption becomes legal. Recently, however, some voices have been raised to suggest that it is time to stop thinking of the granting of the petition as the final scene of a drama in which all the major characters "live happily ever after."

For example, newly developed interest in the dynamics of adoptive family life was created a few years ago by the publication of an article by a psychiatrist in private practice, who found that there was a disproportionate number of adopted children coming to him for treatment of emotional disorders.[2] Similar findings were subsequently reported by staff persons at the Menninger Clinic,[3] and at the Child Guidance Center of Pittsburgh.[4] While these reports have overlooked the possibility that adoptive parents may be more prone than biological parents to use community treatment resources, and have used the wrong population base for their comparisons, their net impact has nevertheless been wholesome in that they have focused attention upon adoptive family life as an important area for family research.

Overall interest in the subject of adoption received another impetus with the recent publication of the findings of the followup study of independent adoptions in the State of Florida.[5] This study did not reveal major differences in the adjustment of adopted children when compared with schoolmates who were reared within their own biological families.

A Theory of Adoption

Dr. Kirk's book represents an attempt to think creatively about adoptive family life and about the kinds of special problems which confront such families. He believes that adoptive parents in our society occupy a decidely anomalous position for which they—and those who must relate to them—are poorly prepared. He starts with the sensible assumption that a married couple does not typically anticipate being childless and that both husband and wife receive a rude shock when they find that they are not fecund. This view is also found in psychiatric literature which emphasizes the threat of infertility to the individual's self-image.

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*Kirk, H. David: Shared Fate: A Theory of Adoption and Mental Health. Free Press of Glencoe, New York. 1964. 192 pp. $4.95.

Dr. Kirk also points out that whereas couples who become parents through their own reproductive resources are able in the gestation period to prepare themselves, their relatives, and friends for their forthcoming parenthood, the adoptive couple is faced with abrupt change in taking a child and has no clear-cut outer signs or a timetable for gradually moving into the parental role.

Dr. Kirk sees adoptive parents as being hampered in their performance as parents by distorted attitudes held toward them by persons in the community at large. In one of his projects, for example, he asked adoptive parents to specify what their own parents' attitudes had been toward their first adoption. While at least 75 percent of the grandparents-to-be expressed approval, Dr. Kirk raises the question why there should be *any* holding back on the part of the older generation.

As a result of this and other studies he has conducted, Dr. Kirk believes that he has uncovered "covert" hostile or confused sentiments in the general population about adoption. Such a specter of unfriendliness will probably surprise most readers who are not themselves adoptive parents. Nevertheless, in this book he propounds the view that adoptive parents have to contend with considerable insensitivity from their contemporaries who have achieved parenthood through biological reproduction.

In building his case, Dr. Kirk makes use of data from a questionnaire mailed to adoptive parents in 1956; they were asked whether they had ever been the recipients of such remarks as: "How lucky you are that you didn't have to go through all the trouble of pregnancy and birth that I did," or, on introduction at a party, "These are those unselfish people with the adopted child," or, from a neighbor, "How well you care for your child, just like a real mother." Most people who responded reported that they had been on the receiving end of such insipid remarks either "occasionally" or "frequently."

In a further attempt to support his thesis of a nonbenevolent attitude toward adoptive parents, Dr. Kirk cites a meeting he arranged in which a group of adoptive parents discussed items on a tentative questionnaire relating to people's attitudes toward adoption. He found the members of the group very tense and reluctant to mention any untoward experience. He then told them about a remark which had been made to his own wife in relation to her care of their adopted child—"Why that's just like a real mother." This evidently opened a floodgate of feelings in the group members about the insensitivity of others to adoptive parents.

It would not seem difficult to dismiss Dr. Kirk's attempt to build a case for a finding of "role handicap" in adoptive parents based on strains stemming from the environment. The data he presents to support his theory are sketchy and some of the responses may have been conditioned by the somewhat dramatic activity of the researcher. The social desirability response-set, which Dr. Kirk's method of making use of his own status as an adoptive parent would tend to create, has been well documented in the psychological literature as one source of invalidity of responses to research questions.

However, despite the faultiness of his data, Dr. Kirk makes an eloquent case for the view that adoptive parents may *occasionally* encounter individuals who find it difficult to view the status of adoptive parents as being truly a *parent* role. Obviously, the man in the street has not been educated specifically on how to address himself to adoptive parents. In the absence of what Dr. Kirk calls a "cultural script," it may well be true that the general public is behaving in a way which may increase the distress of adoptive parents.

We do not know, however, whether adoptive parents react with uniform vulnerability to such assaults upon their sensibilities. This question warrants more rigorous research than has been conducted thus far.

The Role of Agencies

Not only does Dr. Kirk see the general public's role in the lives of adoptive parents as less than positive, he also takes an ambivalent view of social agencies in this regard. He sees adoptive parents not only as being burdened with the oppressive knowledge of their infertility, but also as experiencing a distressing loss of autonomy in having to depend upon a "middleman" in order to acquire a child. And he notes: "This dependence tends to be increased in agency adoptions, which preclude direct transactions between natural and adoptive parents. In a more subtle sense, agency adoptions tend to make the adoptive applicants dependent because there is seldom an overt listing of the agency's criteria for the evaluation of applicants and their eligibility."

Dr. Kirk is also concerned about some of the social work profession's modes of operation, which he berates for its traditional emphasis upon testing for "hereditary potential of the child." However, his evidence for assuming certain orientations in the profession is also rather slim—mainly, memoranda made available from the Oklahoma State Department of Social Welfare in 1951 and from the Louisiana Department of Public Welfare in 1950.

He also shows a churlish concern about efforts to establish professional standards for child placement:

> . . . In the belief that only orderly procedures, governed by such standards, could assure to children a maximum chance of getting into good families, social work has long sought to limit child placing services to licensed agencies. This involved first of all an incessant stream of information and propaganda aimed at educating the public, potential adopters, and practitioners in other professional fields, such as medicine and law. A second step was to obtain legislation that would forbid any third party, not licensed as a child placing agency, to charge for child placing services. In the course of this campaign, carried out in the United States for over a quarter of a century, the official social work point of view was carried to the public by all the mass media of communication.

Through such unwarranted swipes at a group which, he avers, "seeks a monopoly of practice," Dr. Kirk lays himself open to criticism for failing to examine publications which are more current and more central to professional practice than the few pieces of literature he cites. He has obviously not examined the best guide to preferred adoption practice currently available, "Child Welfare League of America Standards for Adoption Service."[6] For example, he criticizes adoption agencies for inducing adopters to think that its social workers can "match" the child "they might have had by birth." Thus he ignores the following statement in the Child Welfare League's guide:

> Similarities of background or characteristics should not be a major consideration in the selection of a family, except where integration of the child into the family and his identification with them may be facilitated by likeness, as in the case of some older children or some children with distinctive physical traits, such as skin color.
>
> The ability of adoptive parents to accept the child as he is or may develop, regardless of how he may differ from them, is of greater importance than similar characteristics. It should be recognized, however, that people vary in their capacity to accept differences.

Methods of Coping

Having forcibly presented the view that adoptive parenthood contains special stresses and deprivations, the author identifies two methods for coping with these problems: (1) The *rejection-of-difference* approach in which the adoptive parent goes to great pains to deny that his situation is any different from that of the biological family; and (2) the *acknowledgement-of-difference* approach in which affirmation of differences is the coping mechanism.

For adoptive parents who would play down the uniqueness of adoption, the facts of the child's having been born out of wedlock and of their own infertility are regarded as essentially unpleasant phenomena which must be explained away. Such an orientation has implications for the ability of the parents to deal with the problem of revealing the adoptive status to the child. Such parents often create myths about the child's origins or they rely upon the defense mechanism of repression, forgetting much of the background information they secured about the child.

Dr. Kirk argues that the *acknowledgement-of-difference* approach is one that, in the long run, can be most effective in stabilizing the family and in developing the most wholesome environment for the child. However, he is critical of what he considers to be the failure of most adoption agencies to be sensitive to the dilemma implicit in the typical social work stress on recommending complete candor with the child about the adoption and about his birth status. Agencies, he says, too often err in insisting that adoptive parents tell the child he is adopted without at the same time helping them to anticipate the pangs of pain that are invariably aroused as these potentially disruptive elements are introduced into the family. He makes an eloquent appeal for more thoughtfulness and better theoretical grounding in this area.

Parents' Organizations

One approach that Dr. Kirk obviously favors in helping adoptive parents meet their condition of "role handicap" through the mechanism of *acknowledgement-of-difference* is to create for themselves the lacking environmental support. He refers favorably to a phenomenon which, as yet, has taken hold only in a few cities: the formation of adoptive parents' organizations or "clubs."

Dr. Kirk is led to a positive view of this phenomenon through his conception of adoptive parents as facing role dilemmas similar to those faced by persons in minority groups. Stimulated by the work of Kurt Lewin, he sees a lesson for adoptive parents in Lewin's advice to Jews during the Nazi period: to learn to "accept their minority group position and make it a position of strength." Although he acknowledges that the problem of an oppressed minority is "in some respects quite unlike that of adoption," he is still intrigued with the many similarities of status between the two. He even sees one advantage that biological parents in a minority group have over adoptive parents: they share with the child the characteristics on which the social stigmas of minority group status are based. This interdependence is not ordinarily available to adoptive parents.

In Dr. Kirk's view, the adopted child, like the Jewish child under oppression, will have to face the fact that he is a member of a less privileged minority group. To do this he needs to build up a positive conception of himself, an ego-building process which is a critical parental task. The parent, Dr. Kirk believes, can best handle this responsibility in consort with other persons in similar straits. He sees parallels between this kind of affiliation, aimed at developing a sense of belongingness, and the affiliation of Negroes to the N.A.A.C.P. and Jews to the American Jewish Congress.

For this reviewer, such parallels seem grossly exaggerated. Membership in such clubs may, as the author believes, serve to reinforce the positive self-images of adoptive parents and give them greater assurance in the tasks they have to perform. However, such membership might also represent overdetermined reactions of a small segment of the population of adoptive parents to their own neurotic difficulties in being parents. Further, such clubs may help to create cultist organizations which can help divorce their members from the mainstream of normal living.

The Natural Parents

Dr. Kirk brings fresh thinking to bear on the question of how adoptive parents handle information about the biological parents of their children. He makes a strong case for the values of open channels of communication between adoptive parents and child and of the ability in the former to present information about the child's natural mother sympathetically.

> . . . For the child to be able to comprehend at all how love could have motivated his first mother to give him up, he requires some additional information. Without it, he might come to fear that being loved in his present home he might again be given up. . . . The child therefore needs certain bare facts to understand his situation. Logically, the facts of birth out of wedlock and its attendant social and psychological problems should help to explain the necessity and desirability of adoption.

For Dr. Kirk, adoptive parents can only be effective in helping the child cope with questions about his background if they can learn to empathize with these phantom-like biological parents. Here, he suggests the novel idea that agencies explore the possibility of a meeting between the natural parents and the adoptive parents before the child is placed. This is a daring suggestion requiring careful thinking through about unanticipated effects.

Dr. Kirk sees the key to success in adjusting to the role of adoptive parents as resting upon the couple's ability to resolve their own feelings about the sexual behavior of the natural mother of their child. He regards it as essential for adoptive parents to be convinced that:

> . . . their own more legitimate situation makes them not one whit more virtuous than the child's natural parents.

> . . . adoptive parents with absolutist sexual ethics will feel restrained from fully throwing in their lot with that of an adopted child who was born of unmarried parents. Indeed, such adopters are likely to see the adoption in part as an "uplift" or "salvage" operation, a circumstance which does not allow for a thorough interdependence of fate.

Dr. Kirk regards a successful adoptive experience as a "shared fate," one in which the lot of each actor is interdependent with the other.

On the book jacket the publishers maintain: "'Shared Fate' is a valuable source book of new information and thought on adoptive relationships." This is a valid statement even though serious reservations must be expressed about much of the data, which provide only a rather tenuous underpinning to the author's formulations. In the absence of *any* theory of adoptive family relationships, the fact that we now have available a carefully thought-through theoretical formulation is a welcome development. That it is out of contact with much of the thinking in today's adoption agencies need not diminish its value as a provocative stimulus to the creation of other theoretical formulations about adoptive family life.

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[1] U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: Facts about children: adoptions in the United States. 1963.

[2] Schechter, Marshall D.: Observations on adopted children. *A.M.A. Archives of General Psychiatry*, July 1960.

[3] Toussieng, Povl W.: Thoughts regarding the etiology of psychological difficulties in adopted children. *Child Welfare*, February 1962.

[4] Sweeney, Dolores M.; Gasbarro, Diana T.; Gluck, Martin R.: A descriptive study of adopted children seen in a child guidance center. *Child Welfare*, July 1963.

[5] Witmer, Helen L.; Herzog, Elizabeth et al.: Independent adoptions: a follow-up study. Russell Sage Foundation, New York. 1963.

[6] Committee on Standards for Adoption Service: Child Welfare League of America standards for adoption service, 1958. Child Welfare League of America, New York. 1959.

Guides and Reports

STANDARDS AND RECOMMENDATIONS FOR HOSPITAL CARE OF NEWBORN INFANTS. American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Ill., 60204. Revised 1964. 89 pp. $1.50.

Among the new recommendations is that the term "premature infant" be replaced by "infant of low birth weight."

HALFWAY TO HEARTBREAK: OUR UNWED TEEN FATHERS. Joan Beck. Florence Crittenton Association of America, 608 South Dearborn Street, Chicago, Ill., 60605. 1964. 16 pp. 50 cents.

Suggests patterns of social service in helping the young unmarried father carry his share of responsibility for the future of his child and for his own future. Includes a section on older fathers of children born out of wedlock.

REVIEW OF LEGISLATION TO PROTECT THE BATTERED CHILD; a study of laws enacted in 1963. Vincent De Francis. Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo. 1964. 22 pp. 25 cents.

A comparison of the language, objectives, and philosophy of State legislation enacted in 13 States in 1963 for mandatory reporting of child abuse cases. The appendix includes the full legal text of legislation in 10 States.

NEUROMETABOLIC DISORDERS IN CHILDHOOD; proceedings of a symposium held at Sheffield, England, in May 1963. Edited by K. S. Holt and L. Milner. E. & S. Livingstone, Edinburgh and London. Available from The Williams & Wilkins Co., Baltimore, Md. 1964. 112 pp. $4.50.

Presents 12 papers on the biochemical aspects of a number of conditions, including phenylketonuria, galactosemia, and mongolism.

MENTAL RETARDATION: A FAMILY CRISIS—THE THERAPEUTIC ROLE OF THE PHYSICIAN. Committee on Mental Retardation, Group for the Advancement of Psychiatry, 104 East 25th Street, New York, 10010. Report No. 56, December 1963. 40 pp. 50 cents. Quantity rates available upon request.

Focuses on the physician's role in helping parents accept the diagnosis of retardation in their child and make realistic long-range plans for the child's care. Appendices include a simplified classification of mental retardation, a reading list for physicians and professional workers, and one for parents.

TOILET TRAINING AS A PREREQUISITE FOR ADMISSION TO A CEREBRAL PALSY PRE-SCHOOL. Virginia Thomas Reaume. Cerebral Palsy Association of Western New York, Inc., 309 North Street, Buffalo 1. 1964. 9 pp. 15 cents.

Describes the various types of help that the Cerebral Palsy Association of Western New York provides to children who are admitted to its preschool program in spite of the fact that they are not toilet trained.

OPPORTUNITIES IN SOCIAL WORK CAREERS. Joseph P. Anderson. Vocational Guidance Manuals, Universal Publishing and Distributing Corporation, 800 Second Avenue, New York, 10017. 1963. 128 pp. $1.45 paperback; $2.65 clothbound.

Describes the variety of opportunities offered in social work careers, discussing the development of social work as a profession and presenting information on social work education, organization patterns, and services performed by social workers in various types of agencies and organizations.

BOOK NOTES

THE GROWTH AND DEVELOPMENT OF THE PREMATURELY BORN INFANT. Cecil M. Drillien, M.D. Foreword by Richard W. B. Ellis, M.D. The Williams & Wilkins Co., Baltimore, Md. 1964. 367 pp. $9.50.

On the basis of a series of studies conducted in Edinburgh, Scotland, since 1954, the author, lecturer in the Department of Child Life and Health at the University of Edinburgh, answers some questions and poses others about the growth and development of both prematurely born and full-term infants from birth through their early school years.

Attention is given to the usefulness, findings, and unresolved questions of previous studies done in this century. Two of the 10 chapters are devoted to the planning of a longitudinal survey, referring to current studies and outlining the procedures and methods of the Edinburgh survey. Other chapters are concerned successively with methods of classifying the families of the premature infants and the control groups, and with comparative data on physical development, health, and sickness in the first 5 years, and the varied patterns of maternal care, mental development, and behavior in the preschool and early school-age periods. The final chapter presents findings of a sample survey of 24 infants weighing 3 pounds or less at birth.

Graphs, tables, charts, and one photograph are included. Each chapter is followed by a list of references.

CHILDREN OF THE DEVELOPING COUNTRIES: a report by UNICEF. The United Nations Children's Fund. The World Publishing Company, Cleveland, Ohio. 1963. 130 pp. $3.95.

That "the adult can sometimes wait for things to improve, but the growing child cannot" is among the thought-provoking comments that accent this story about what the United Nations Children's Fund is doing for children in developing countries. Colored throughout by the concept that "we must prepare as well as protect the child," the book spotlights the prominent needs of these children—who number about half a billion—and the policy questions that meeting these needs generate. It outlines ongoing programs and the opportunities to do more, in health, nutrition, education, vocational training, and family and child welfare.

THE RESIDENTIAL TREATMENT CENTER: children, programs, and costs. Lydia F. Hylton. Child Welfare League of America, New York. 1964. 251 pp. $5.

The cost of care and treatment of emotionally disturbed children in residential centers is the focus of the study reported in this book. The report also covers the centers' operations, the populations served, and the administrative concerns of the workers directing the operations.

The study, conducted by the Child Welfare League of America with funds from the Field Foundation, reports on 21 public and private residential treatment centers located in various parts of the country and on 2 therapeutic day schools.

The more than 900 children cared for in the centers studied ranged in age from 5 to 21; the median age was 12.

Actual costs in these centers ranged from about $4,000 to $18,000 per child-year, including depreciation and the cost of maintaining empty beds—the wide variation being due to their many differences, especially in the ratio of professional staff to children under care. Only one out of six children referred for care in the period of study was accepted.

The study found that the fees charged in the residential treatment centers did not nearly cover the cost of care, although the median fee charged in such centers was estimated to be $3,600. The fee scales of most of the centers were reported as flexible, with private and public agencies contributing all or part of the discrepancy between fee and cost. Among the 17 centers in which cost analyses were made, only one had a top fee which surpassed its per-child-year cost; the rest had discrepancies ranging from $357 to $17,467, the median being $2,577.

The average length of stay of discharged children was slightly more than 2½ years.

WEDNESDAY'S CHILDREN: a study of child neglect and abuse. Leontine Young. McGraw-Hill, New York. 1964. 195 pp. $5.95.

This book reports on a study of 200 cases of severe child neglect and abuse. It describes parents who use extremely cruel methods to abuse, torture, even murder their children. According to the findings, many of these parents were themselves neglected or abused as children and never learned what love was. Some hate their children and tell them so. Generally, they are indifferent to the child's school attendance, personal hygiene, and clothing.

The author, professor of casework in the School of Social Administration at Ohio State University, sees a common thread running through these cases: Lower-than-average living standards, loosely knit family patterns, unemployment, limited education, substandard health care, isolation from the neighborhood, and acutely deviant personal behavior (alcoholism, prostitution, drug addiction). She suspects that these parents are most frequently found in crowded urban areas.

Such parents, Dr. Young reports, rarely seek help for their disorders or family problems. She points out that although they do come to the attention of a variety of community institutions—courts, schools, social agencies—only fragments of their problems are recognized, since each agency tends to perceive the mother and her children within the confines of its own specific function. The author therefore concludes that many cases of child abuse never reach a child welfare agency.

Maintaining that no service discipline knows how to treat such parents, Dr. Young makes a plea for the development of a community structure for early identification, reporting, and handling of abuse cases, and for the correction of the social ills which aggravate parental pathology.

THE ECONOMIC OPPORTUNITY ACT OF 1964

On August 20, the President signed the Economic Opportunity Act of 1964. The Act authorizes appropriations totaling $947,500,000 for the fiscal year 1965, and such sums for the following 2 years as the Congress shall determine, to combat poverty in the United States.

Title I, with a $412,500,000 authorization, provides for: (a) a Federal Job Corps to provide young men and women aged 16 through 21 with education, vocational training, useful work experience, and other appropriate activities in rural and urban residential centers; (b) federally aided State and community work-training programs for unemployed young men and women; (c) federally aided work-study programs to provide part-time employment for needy students in institutions of higher education.

The ***Job Corps*** is to be established within the Office of Economic Opportunity. The Office's director may enter into agreements with any Federal, State, or local agency or private organization for the establishment and operation of conservation camps and training centers in rural or urban areas and may provide or arrange for useful work, training, educational and other activities for the enrollees, including, but not limited to, conservation work. Enrollees may be provided with living, travel, and leave allowances, health services, and appropriate equipment and clothing and for a readjustment allowance on leaving of not more than $50 for each month of participation.

Work-training programs for unemployed youth developed by State and local agencies and nonprofit organizations, on agreement with the Office of Economic Opportunity, may receive Federal aid up to 90 percent of the cost for the first 2 years of the Act's effectiveness and up to 50 percent thereafter. They must be designed: to increase the enrollee's employability or enable him to go to school; to contribute to a service in the public interest; to avoid displacement of employed workers; and to provide reasonable rates of pay; and must, insofar as feasible, be coordinated with public vocational training and education services. The work provided must be on public projects or on projects sponsored by private nonprofit organizations other than those connected with religious worship or instruction.

Work-study programs offered by institutions of higher education for students who need employment in order to pursue their studies may be underwritten by the Federal Government up to 90 percent of the cost for the first 2 years of the Act's effectiveness and 75 percent thereafter. Ninety-five percent of the Federal grant must be used for payments to students for part-time work performed for the institution or for a public or nonprofit organization if the work is not on a facility used for "sectarian instruction or as a place for religious worship."

Title II, with a $340 million authorization, provides for grants to public or nonprofit corporations or combinations of such for urban and rural community action programs; grants to the States for adult literacy programs; and the establishment within the Office of Economic Opportunity of an information and coordination center to encourage voluntary assistance to "deserving and needy children."

The ***community action programs,*** which may be federally supported in full or part, are to combat poverty through "developing employment opportunities, improving human performance, motivation, and productivity, or bettering the conditions under which people live, learn, and work." They must be conducted "with the maximum feasible participation" of the groups served.

In addition to the program grants the Director of Economic Opportunity may provide and make grants to the States for technical assistance to communities developing such programs, and may conduct or arrange for research, training, and demonstrations in connection with such programs.

Title III, with an authorization of $35 million, provides for special programs in rural areas: loans to low-income families to improve property or farm operations and to finance supplementary nonagricultural enterprises; assistance in the establishment of programs for agricultural migrants; and indemnity payments to dairy farmers who suffered losses because of certain Federal actions.

The programs for agricultural migrants are specified as housing, sanitation, education, and the day care of children.

Title IV provides for loans to small businesses.

Title V, with an authorization of $150 million, provides for transferring funds to the Secretary of Health, Education, and Welfare to meet the costs of experimental work-training programs to "help unemployed fathers and other needy persons."

Title VI, with an authorization of $10 million, establishes the Office of Economic Opportunity in the Executive Office of the President, with a director charged with implementing the Act, spells out its methods of staffing and operation, and provides for the establishment for a corps of volunteers to be known as the Volunteers in Service to America.

The volunteers are to be recruited, selected, and trained by the director and referred, upon request, to State, local, or private nonprofit organizations to perform duties in furtherance of programs combating poverty; and to work in programs serving Indians on reservations, migratory workers and their families, and residents of District of Columbia, Puerto Rico, and U.S. dependencies, and in facilities caring for the mentally ill or retarded.

Title VII prohibits denying unemployment compensation to persons because of their participation in any of the programs provided for in Titles I and II; and provides for exemption of at least $85 of payments made to a person for such participation in determining his need for public assistance.

HERE AND THERE

Health Grants

In mid-July, the Children's Bureau announced the initial grants made under the increased appropriations and new programs authorized by the Maternal and Child Health and Mental Retardation Planning Amendments to the Social Security Act. (See "Accent on Prevention Through Improved Service," by Arthur J. Lesser, M.D., CHILDREN, January–February 1964.)

High Risk Maternity Cases

Seven grants were made under the new 5-year program to aid mothers and infants regarded medically as high risks. The recipients, which must shoulder at least 25 percent of the cost, were: The New York City Health Department; Richmond County Health Department in Georgia for that county and 10 surrounding counties; Puerto Rico Department of Health for the San Juan area; West Virginia Department of Health for the Morgantown area; Michigan Department of Health for Detroit; Baltimore City Health Department; and Illinois Department of Public Health for Chicago. Their projects will seek to increase the number of prenatal and post-partum clinics; pay for hospital inpatient care in voluntary hospitals; expand the medical, nursing, social work, and nutrition staffs of hospitals; expand public health nursing staffs; provide carfare to mothers of low-income families for travel to and from clinics; provide homemakers to teach these mothers good child care practices; and use trained nurse-midwives to provide direct service to patients. They will focus especially on building up services in areas with high rates of prematurity, infant mortality, and lack of prenatal care.

Ongoing Health Programs

Under the increased authorization of $5 million each for the regular Federal-State maternal and child health and crippled children's programs, the Bureau made grants to 10 State health departments and crippled children's agencies to expand services for mentally retarded and multiply handicapped children and to 19 institutions of higher learning for special projects to focus on the training of personnel for these and related services.

The States' expansion of services will include enlarging and increasing diagnostic and treatment clinics; the initiation of clinical evaluations of children in institutions; the extension of screening programs for detection of mental retardation; and the establishment of treatment services for mentally retarded children who are also physically handicapped. The recipient States are: Idaho, Minnesota, New Mexico, Maryland, New York, Tennessee, Iowa, Texas, Georgia, and Pennsylvania.

The university projects will focus on training personnel for services for the mentally retarded and the multiply handicapped, training in nurse-midwifery, and the establishment of genetics laboratories for training personnel for genetics counseling services. Included, for example, were grants to:

- The Medical School of the State University of New York at Buffalo for a new genetics laboratory to provide facilities for detection, diagnosis, and study of inborn and other errors of metabolism and chromosomal abnormalities. Genetic counseling will be a consultative service to the pediatrics department.
- The Nebraska Psychiatric Institute, University of Nebraska, to develop personnel training resources and facilities for evaluation and counseling of multiply handicapped children and their families.
- The Baylor University College of Medicine for an evaluation and treatment clinic for mentally retarded infants and young children that will provide training opportunities for medical students, pediatric interns and residents, and students in psychology, social service, nursing, and education in relation to mental retardation.
- The University of California at Berkeley to set up a training program for medical personnel in the administration of programs for mentally retarded children and to strengthen the teaching program of the School of Public Health concerning mentally retarded children with multiple handicaps.

Health Research

The Bureau's initial grants under the new maternal and child health and crippled children's services research program were focused on developing programmatic research (see "Child Welfare Research," page 200) in the maternal and child health departments of selected schools or university departments of public health. In addition to carrying on significant service-related research, these schools of public health are to act as regional research consultants to the local State, county, or city health officials in regard to studies of infant mortality, prenatal care, and crippled children's services. They are: Columbia Univresity; University of California, Berkeley; University of North Carolina; University of Puerto Rico; Harvard University; Tulane University; and the University of Michigan.

Research grant recipients included:

- The Department of Biostatistics, Harvard School of Public Health, for development of a series of national studies for the assessment of the health status of mothers and children and the availability and utilization of health facilities in a selected sample of high-risk communities.
- The Tri-County District Health Department, Aurora, Colo., for the construction and testing of a maternal health index.
- The Visiting Nurse Association of the Denver Area, Inc., Denver, Colo., for developing a method for evaluating the quality of nursing service to maternity patients.
- The Childrens Hospital of Los Angeles, Calif., for a study into ways of bridging gaps in doctor-patient communication.
- The American Speech and Hearing Association for a study of hearing aid evaluation procedures
- The Columbia University School of Public Health and Administrative Medicine for a study of health and medical care of mothers and children in an urban community.
- The University of California Medi-

cal Center, San Francisco, for a study of children's lower-extremity orthopedic problems.

- The Emory University School of Medicine for an investigation of reproductive wastage in a high-risk urban indigent population.
- The Johns Hopkins University School of Hygiene and Public Health for development and evaluation of a self-administered health questionnaire for school children.
- The University of California at Los Angeles for a study of a legged walker for child amputees.
- The University of Michigan for a study of methods for evaluating the speech and behavior changes which accompany therapy programs for children with oral clefts.

Planning Grants

Under the authorization for community planning grants, provided for by the same amendments to the Social Security Act, the Public Health Service had by mid-July made grants of $30,000 each to 42 States and territories for planning comprehensive programs of prevention, treatment, and amelioration of mental retardation. The States must pay at least 25 percent of the total planning cost to be eligible for a planning grant.

Child Welfare Research

In recognition of the acute shortage of competent research personnel knowledgeable in the areas of child welfare, mental retardation, and maternal and child health, the Children's Bureau during the past year has initiated a new phase in research strategy in its programs of child welfare research and demonstration grants and the newly approved maternal and child health and crippled children's services research grants. (See page 199.) This is the encouragement of programmatic research—a long-term commitment by the research agency to a specific aspect of the program field, entailing two or more intensive studies of related problems by personnel knowledgeable and career-directed in the problem areas. The purpose is to develop a basic continuing institutionalized framework for seeking knowledge that has meaning for the advancement of the programs and services with which the Bureau is concerned.

Thus in the field of child welfare, grants have been made for programmatic research in the area of child care to:

- The Child Welfare League of America to conduct a coordinated research program in foster care focused upon the problems and practices in all types of placement services for children.
- The Jewish Board of Guardians, a voluntary agency in New York, to concentrate on what can be done to increase family capacity for child care in order to avoid total separation of children from their parents.
- The School of Social Service Administration, University of Chicago, to look into the circumstances under which social work intervention culminates in parent-child separation.
- The Columbia University School of Social Work for studies regarding children not being well served by existing programs.
- The Center for Urban Studies, University of Chicago, for a series of national studies relating to the adequacy of the physical facilities used for the group care of children under social work auspices.

Other programmatic research grants have been made for research relating to legal authority, law, and legal processes as they affect child welfare services. They went to:

- The School of Law, Columbia University, for a study of child welfare agencies and legal authority; and for a study of State legislation concerning abused children.
- The School of Law, University of California, to study the impact of law upon the mental, physical, and moral health of the family unit.

Other grants for child welfare research were recently awarded to:

- Comeback, Inc., New York City, to study availability and use of recreation resources for chronically disabled children.
- The Massachusetts Fund for Children and Youth to investigate the use of community health and welfare services for children.
- The Washington Center for Metropolitan Studies, Washington, D.C., to study legal protections for children with mental disorders.
- The University of Chicago to investigate the evaluative designs of all child welfare demonstration programs.

Recently awarded grants for child welfare demonstrations have gone to:

- The Jewish Vocational Service of Chicago to demonstrate the integration of vocational services with existing treatment programs for emotionally disturbed adolescents.
- The Camp Fire Girls, Inc., to demonstrate the use of small voluntary groups to strengthen the physical, emotional, and cognitive development of mentally retarded and culturally deprived girls.
- The Rhode Island Department of Social Welfare to demonstrate the use of day-care services as an integral part of the program of aid to families with dependent children.

Against Delinquency

Late in June, Congress extended for 2 more years the provisions of the Juvenile Delinquency and Youth Offenses Control Act of 1961. The Act authorizes a $10 million appropriation for the fiscal year 1965 but leaves authorization for fiscal 1966 for future congressional action. In addition, it authorizes $5 million for a special project to be carried out in the Washington, D.C., metropolitan area to demonstrate "the effectiveness of a large-scale well-rounded program for the prevention and control of juvenile delinquency and youth offenses." The program will include among other things guidance and counseling services to supplement those provided by the school system and the establishment and operation of halfway houses.

The Act also directs the Secretary of Health, Education, and Welfare to make a special study of compulsory school attendance laws and regulations in relation to their effects on juvenile delinquency and youth offenses. An interim report is to be transmitted to Congress on or before June 30, 1965, and a final report by January 31, 1966.

. . .

The Office of Juvenile Delinquency and Youth Development has recently awarded to the Houston Action for Youth, Inc., Houston, Tex., a grant for a demonstration project which will focus on the neighborhood organization, the development of services, and a youth employment program. Residents of disadvantaged neighborhoods will be helped to recognize problems, to identify what they themselves can do about them, and to know how they can make their needs known to the decision makers of the community and join with them to bring about social changes. The neighborhood activity is to be an integral part of planning for modification and expansion of services, a process in which representatives of the service structure and the community at large will also be involved.

The youth employment program will experiment with new approaches and techniques in providing counseling and training for unemployed out-of-school youth between the ages of 16 and 22 and in recruiting and training its own staff members.

Child Welfare

A new State law requiring the reporting of suspected child abuse went into effect in New York State on July 1 of this year. Passed in the 1964 general legislative session, the law requires physicians, dentists, or superintendents of hospitals or other institutions to report suspected cases immediately—either to an authorized child protective agency or to a public welfare official. The law provides immunity from civil or criminal liability for persons making such reports in good faith.

In response to the New York legislation, the New York City Department of Welfare has set up a central registry for the recording of abuse reports, located within a newly established child protective services unit in its Bureau of Child Welfare.

Louisiana has a similar law, also passed in 1964, but this requires that cases be reported to a law enforcement, rather than a welfare, agency.

. . .

The abuses, dangers, and possibilities of foster care in meeting the needs of children from broken or unstable families were the subjects of 3 days of discussion in Oakland, Calif., in mid-June by 26 child welfare specialists who met together under the sponsorship of the National Study Service, the California State Department of Social Welfare, the California Youth Authority, and the Alameda County (Calif.) welfare and probation departments. Purpose of the meeting was to discuss ideas for new approaches to meeting children's needs.

The discussion, which focused on 31 cases, proceeded from two basic assumptions: (1) the importance of using every service available to strengthen the ability of the child's own family to provide him with adequate care; (2) the importance of early recognition of situations in which this is not a realistic goal so that a permanent plan—preferably adoption—can be made for the child.

THE CIVIL RIGHTS ACT OF 1964

The Civil Rights Act of 1964, signed by the President on July 2, contains 11 titles banning discrimination because of race, color, or national origin:

Title I bans discrimination in voting where Federal offices are involved, and prohibits registrars from using different standards for voters.

Title II bans discrimination in public accommodations: hotels, motels, and other lodgings except owner-occupied places with not more than five rooms for rent, and eating places, gas stations, and places of entertainment.

Title III bans discrimination in public facilities, including hospitals, libraries, parks, and swimming pools owned, operated, or managed by State or local governments.

Title IV authorizes the U.S. Commissioner of Education to extend technical aid to State and local officials involved in school desegregation and to provide training for teachers in problems produced by desegregation.

Title V extends the life of the Civil Rights Commission 4 years.

Title VI bans discrimination in programs aided by Federal grant, loan, or contract against any person because of race, color, or national origin.

[Regulations of the Department of Health, Education, and Welfare pursuant to this title are awaiting the President's signature.]

Title VII bans discrimination by many employers, labor unions, and employment agencies in hiring, firing, promoting, or referring workers because of race, religion, or sex. Effective 1965, this section will cover only employers and unions with 100 or more workers or members. The number covered drops by 25 each year, reaching a minimum of 25 in 1968.

Title VIII orders the Secretary of Commerce to compile statistics on voting in areas selected by the Civil Rights Commission.

Title IX allows the Attorney General to intervene in any civil rights case brought under the 14th Amendment if he certifies it is of general public importance.

Title X sets up a Community Relations Service in the Department of Commerce to work for voluntary compliance with the Act.

Title XI provides for a jury trial in all criminal contempt cases arising under Titles II through VII of the Act.

Among the many suggestions made for improving services were:

- Subsidizing adoptive families who could not otherwise afford to take a child in care—with a time limit on the financial aid.
- Assumption of guardianship by foster families for children in long-time foster care.
- Agency employment of foster parents with requirements that they attend agency training sessions.
- The encouragement of specialization among foster families.
- The establishment of group homes focused on the child's stage of development.

Adequate payment of foster families, improved casework services, low caseloads, and a wide range of supplementary community services were repeatedly stressed as essential to any child-care program.

The National Study Service is preparing a full report of the meeting which will be published in the near future through the cooperation of the California State Department of Social Welfare.

Unmarried Mothers

A guide for collaboration of physician, social worker, and lawyer in helping the unmarried mother, developed by representatives of the three professions concerned, has recently been released for distribution by the four organizations which have formally approved it: The American College of

Obstetricians and Gynecologists, the American Academy of Pediatrics, the Child Welfare League of America, and the Children's Bureau. Pointing out that each of the three professions is responsible for advising the unmarried mother to consult with a member of the other two, the guide outlines the specific responsibilities of each discipline.

The physician is "held responsible for the physical and mental health of the patient" but is specifically advised not to become involved in any way with the placement of the infant.

The social worker is held responsible for the "distinctive social and emotional problems connected with having a child out of wedlock," including counseling the patient on plans for her own and her child's future.

The lawyer for the unmarried mother is held responsible for counseling her on the legal consequences of keeping or giving up her child and on her legal rights in respect to the child's father. He is advised against representing the prospective adoptive parents or becoming involved in any way with the placement of the infant.

All three disciplines are held responsible for recognizing the right of the unmarried mother to make decisions for herself and her child—"except where such rights are involuntarily terminated by court action"—and for individualizing each case in dealing with specific problems.

Copies of the complete text of the statement are available from the Children's Bureau without charge.

Sex Education

Two workshops on the changing sex values of today's youth were held in New York this spring under the auspices of the National Social Welfare Assembly—one on March 31, the second on June 11—for the representatives of youth-serving agencies. Before beginning their deliberations in the first workshop the participants listened in on half-hour discussions of the subject by two groups of anonymous young people—one composed of five high school, business school, and college girls; the other, four college men, all freshmen. Each young people's group had an adult leader.

The young people told of their own and their friends' attitudes toward sex experiences, on the whole testifying that there is a great deal of heavy petting and sexual intercourse among boys and girls of high school and college age, which seem to have little or no relation to love. They spoke with satisfaction about the factual information they received in social hygiene and sex education courses but strongly expressed a need for opportunities to talk over with an adult the problem of sex in relation to their own behavior and the possible consequences of sexual experimentation. They reported that the barriers between themselves and their parents on this subject were too high to be scaled.

The workshop participants then considered the meaning of what the young people had said for the policies of their own agencies, especially in relation to providing guidance for young people, and the potential role in this of the youth leaders in their employ.

The second session of the workshop dealt with additional questions of policy and guidelines for sex education in informal settings. Program resources such as publications, films, and recordings were discussed.

Mental Retardation

Thirty-nine cases of phenylketonuria (PKU) were found among the 400,000 newborn babies given a blood test between July 1962 and December 1963 in field trials of the Guthrie "inhibition assay," according to a report recently prepared by Robert Guthrie, M.D., and Stewart Whitney of Children's Hospital, Buffalo, N.Y. The field trials of the screening method developed by Dr. Guthrie were carried out by State health departments in 29 States in cooperation with the Children's Bureau. (See CHILDREN, September–October 1963, page 201.) The findings showed an incidence of approximately 1 in 10,000, as compared with an expected incidence of 1 in 20,000.

The report maintains that the field trials have demonstrated the practicality of the inhibition assay method for universal screening of newborns; and that early detection of all cases through such screening, coupled with the use of the available low phenylalanine diet, makes the eradication of mental retardation due to phenylketonuria an obtainable goal.

It also refers to current investigations at the Children's Hospital in Buffalo to determine the possibility of developing a "multiple test" for a number of other rare inborn errors of metabolism, using the same blood obtained for the PKU test.

Published by the Children's Bureau, the report, "Phenylketonuria Detection in the Newborn Infant as a Routine Hospital Procedure," is available from the U.S. Government Printing Office, Washington, D.C., 20402. (Price: 30 cents.)

. . .

The Children's Bureau is recommending that the States take steps to insure the routine testing of all newborn infants for phenylketonuria. Four States, Louisiana, Massachusetts, New York, and Rhode Island, have already enacted legislation making such testing mandatory. In addition, Illinois and Oregon have enacted permissive legislation. In California the legislature has directed that a committee prepare a report on the need for compulsory testing to be presented to the 1965 legislative session. Other States—for example, Minnesota—are launching statewide PKU testing programs by requirement of the State department of health.

. . .

With a grant of $2,200,000 from the Joseph P. Kennedy, Jr. Foundation, the University of Chicago is launching a multidisciplinary attack on mental retardation. Two-thirds of the grant will be used to establish a mental retardation research center, the remainder to establish a mental retardation clinic and training facility.

Smoking

Twelve national health and education groups, with a membership of nearly 4 million people, organized the National Inter-Agency Council on Smoking and Health at a meeting held at the National Library of Medicine, Bethesda, Md., in early July. Directed toward youth, the council's purpose is to "develop and implement effective plans and programs aimed at combating smoking as a health hazard." Among the 12 are 3 Federal agencies: Office of Education, Public Health Service, and the Children's Bureau.

Photo Credit

Frontispiece, Esther Bubley for the Children's Bureau.

READERS' EXCHANGE

REINHERZ: *A Connecticut program*

In her article on "The Therapeutic Use of Student Volunteers" (CHILDREN, July–August 1964), Helen Reinherz describes the effects of the experience of companionship on mentally ill patients. Since 1957 a companion program has been in operation at Connecticut Valley Hospital in Middletown, Conn. Under the direction of Dr. Jules Holzberg, director of psychological laboratories at the hospital, the program has expanded until it now includes over 150 students from 7 local colleges.

In contrast to the Harvard program, the focus of the research aspect of the Connecticut program has been directed toward the effects on the students rather than on the patients. The studies have demonstrated the following positive changes: a more realistic knowledge and understanding of mental illness; more positive attitudes toward the mentally ill; greater introspectiveness and self-acceptance; and greater tolerance for other people's sexual and aggressive behaviors. Future studies will be directed toward determining the persistence of these changes, to examination of the personalities of students who volunteer for the program, and the effects of using various combinations of students and patients.

In regard to the last point, 17 students were assigned to the children's service for the 1963–64 year. While the basic procedure was similar to the Harvard program, several exploratory modifications were initiated. In selecting patients, the primary criteria were the youngster's need for, and ability to profit from, such an experience and the facts that they were not considered "short-term" cases and were not receiving a variety of other social experiences. The boys and girls, 7 to 16 years, had diagnoses of schizophrenia, character disorder, or organic impairment.

The assignment of students to patients, with a few exceptions, was made by the individuals themselves: All were present at two social gatherings, and with some help were able to pair off satisfactorily. Aside from a general orientation, the students were not given information about the youngsters' backgrounds and problems until halfway through the year. This permitted the students to perceive the patients as children rather than mental patients.

As this was in general an exploratory procedure, definitive conclusions cannot be drawn. However, on the basis of interviews with all interested parties, the companion program was judged to be beneficial to the patients, to the students, and to the hospital functioning.

Roy Korwin
Chief Psychologist, Children's Service, Connecticut Valley Hospital, Middletown, Conn.

BEALER et al.: *Authors' rejoinder*

Irene M. Josselyn in "Some Reflections on Adolescent Rebellion" (CHILDREN, May–June 1964) rejected the idea that a rebellious youth subculture is a myth, as we contended in the March–April 1964 issue of CHILDREN ("The Rebellious Youth Subculture—A Myth," by Robert C. Bealer, Fern K. Willits, and Peter R. Maida).

Through the example of the American Colonies' revolution against England, she notes that rebellion normally takes place within a system of shared values and focuses on the legitimacy of authority patterns. We have no quarrel with this meaning of rebellion. In fact, Dr. Josselyn's analogy very nicely points to one of the major contentions of our article. Put simply, the "great gesture" that the youth often makes of his rebellion should not be taken to mean total rejection of his parents. Just as the Colonies following their "rebellion" remained very "British" in culture, so adolescents who break with parental authority usually do not reject the basic ideals of their family.

However, there is a large body of writing which takes adolescent rebellion to mean a conflict over values and not one limited to authority patterns within values. Dr. Josselyn is not exempted here. Having argued persuasively that rebellion *can* occur without total rejection of parental values, she goes on to reverse herself by contending that adolescents "revolt against parental standards," and that while the "adolescent will verbalize standards that are derivative of parental standards . . . his behavior will be quite to the contrary."

We do not deny that conflict over authority occurs. Whether it necessarily signals rejection of basic parental values and whether it happens within most American parent-child relationships, as Dr. Josselyn contends, are other matters. The conclusion of our article, based on a large quantity of research evidence, was that authority conflict can occur independently of value conflict and that a high degree of value similarity between generations is the mode. Dr. Josselyn gave no data to challenge that conclusion.

In regard to the question of how widespread conflict over authority is, we simply do not know. Undoubtedly, Dr. Josselyn feels that this type of rebellion is extremely widespread. It is our impression that authority conflict is not so prevalent. However, neither her position nor ours had been adequately documented by empirical research.

Much of Dr. Josselyn's uneasiness with the points we made seems to center on a reluctance to accept certain facts which are contrary to her own ideals of what is desirable in terms of personality development. For example, she writes with considerable dismay:

> If adolescents are already so fixed in their attitudes, we should abandon our courses in philosophy or any others that we feel influence a resolution of the adolescent's confusion, a confusion based upon his need to find his own identity as an individual rather than remaining simply a reflection of his parents.

Without examining the questionable assumption that confusion is vital to adolescent growth, it seems fair to point out two things: (1) To suggest that adolescents are not overwhelmingly rebellious is not necessarily to condone that acquiescence; (2) To conclude that it is necessary to give up efforts at change is simply not warranted. If change is to be brought about the starting point *must* be an accurate picture of reality. To point out the tendency for continuity in values and the subsequent difficulties of eliciting change does not mean alterations are impossible. It does emphasize the fact that the task is not simple.

Dr. Josselyn also was disturbed that we did not "consider the average adolescent . . . a member of a subculture because he has many values in common with adults," but with the same condition of partly shared and partly different values, allowed social class as a subculture. There is a simple misunderstanding here. In certain ways and on many occasions adolescents do constitute a subculture. What we did question is the image of a youth subculture rejecting parental values as "the characteristic or most widespread pattern of adolescent behavior."

Furthermore, through an example suggesting the relationship of the continuity of culture to the high school dropout problem, we showed that relying heavily on a youth subculture concept may not be the most insightful choice for fruitful analysis.

Robert C. Bealer
Fern K. Willits
Peter R. Maida
Department of Rural Sociology, Pennsylvania State University

HUNT: *What kind of poverty?*

J. McVicker Hunt's survey of our advancing knowledge of the intellectual development of children and his (as always) skillful relating of experimental findings to pragmatic considerations are much appreciated by this practitioner in the child welfare field. ("How Children Develop Intellectually," CHILDREN, May–June 1964.)

Because Dr. Hunt does such a fine job of substantiating impressions with facts, I was surprised to see some rather sweeping generalizations about poverty and its implications for the intellectual development of children. Specifically, poverty is said to feature crowding, adults ill-tempered because of discomforts and frustrations, and children's questions inadequately answered and sometimes provoking punishment.

This leads me to wonder just how much we do know about the features of poverty, and to ask how carefully have we defined the terms and concepts we use to describe this social (cultural, economic) phenomenon. There seems to be a tendency to use interchangeably (at least in the context of this article) the terms *low socioeconomic class*, *poverty*, and *cultural deprivation*. Of these, the first concept is the best understood and most consensually validated; the second is in the process of achieving acceptable definition; and the third is still subject to debate as to just what is meant. My own reaction is that the three terms are not necessarily correlated: There can conceivably be "lower class millionaires," cultural deprivation is found in all classes, there *is* an impoverished middle class and a culturally advantaged lower class.

We all "know" what is meant by these terms when used in this context, but is not our model usually the particular kind of poverty each of us knows best, most often the urban slum (where crowding *is* a problem)? What about the rural slums of Appalachia, small town poverty, agricultural and open country poverty, poverty brought on by technological unemployment or the physical disability of middle age?

In sum, there would seem to be a need for a great deal more clarification of these concepts, and particularly when they have such immediacy to many ongoing and proposed programs in nursery and grade schools, adoptions, vocational training, and foster care.

Henry Kite
Social Worker, Vermont Children's Aid Society, Springfield, Vt.

Author's reply

Henry Kite's call for a more careful and differentiated specification of the relationships among poverty, low socioeconomic class, and cultural deprivation is valid.

Although I suspect that crowding (with its attendant variety of input for infants during their first months after birth) and the ill temper of adults (arising from their discomforts and frustrations and resulting in a dampened parental responsiveness to infant locomotion and verbalization) are nearly universal concomitants of severe poverty, this is not the whole story.

When I say crowding and ill-tempered adults are well-nigh universal concomitants of poverty, I must confess that my empirical knowledge of poverty is limited. I have seen these concomitants in the rural shacks of the hand workers in the sugar beet industry, where I grew up. I have glimpsed them in the rural slums of Navajo country. I have seen them in the urban slums of New York City and Providence, R.I. Moreover, I suspect that Oscar Lewis is correct in his belief that he is describing a universal condition of poverty in his "The Children of Sanchez," which paints conditions not too diverse from those in which children whose parents are facing dire poverty in this country are growing up. But this impression of poverty is only a hypothesis for proper investigation.

On the other hand, Henry Kite is correct in saying that ill-tempered parents exist within the middle and upper classes. Although I suspect that they are less common than they are within the poverty-stricken of the lower and especially the lower, lower class, their existence makes it entirely feasible to find a substantial range of parent-child relationships within the middle and upper classes which might well be investigated for their effects on the developing intellects and personalities of their children.

Other factors are also involved in development. Dr. Norman Frederiksen of the Educational Testing Service, who has recently visited the bush-reared natives of Kenya, Africa—a people generally very responsive to their children—reports that these people do not recognize very familiar objects in pictures, either as children or as adults, unless they have had considerable contact with Western civilization. This implies that factors within the informational interaction of persons with their environment must be especially important in cognitive development. These factors are still not clearly specifiable, but they probably reside in encounters with two-dimensional representations and linguistic signs of objects.

Within our society, such factors in informational interaction are more typically available in the middle and upper classes than the lower. Such factors could readily be supplied by nursery schools and day-care centers.

As of now, I have no knowledge that permits more definite specification. Only if we attempt to develop programs with the purpose of fostering the intellectual and personal development of those children from slum backgrounds who, without them, are handicapped even on entering kindergarten can we expect to specify more definitely and clearly the relationships among poverty, low socioeconomic class, and cultural deprivation, and the factors most important for fostering the achievement of intellectual potential.

J. McVicker Hunt
Professor of Psychology, University of Illinois

U.S. GOVERNMENT PRINTING OFFICE: 1964

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

INSTITUTIONALIZING MENTALLY RETARDED CHILDREN: attitudes of some physicians. Simon Olshansky et al. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 22 pp. Single copies available from the Bureau without charge.

The four reprints from professional journals included in this publication report on interviews in the Greater Boston area with 18 obstetricians, 30 pediatricians, 57 general practitioners, 20 hospital interns, and 20 first-year resident physicians. The large majority of physicians in each group favored keeping the preschool retarded child at home: almost all opposed separation of mother and retarded child at time of birth; very few considered the parents as the decision makers in determining institutionalization.

A NEW APPROACH—RELIEF ROLLS TO PAYROLLS; a community work and training program under the Public Welfare Amendments of 1962. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services. PA1–8. 1964. 7 pp. Single copies free of charge from the Bureau of Family Services.

Describes typical work and training programs for public assistance recipients that State public welfare departments can provide with Federal financial participation.

FEES FOR DAY CARE SERVICES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 20 pp. 15 cents.

This pamphlet suggests some principles and methods to be considered by agencies in establishing a flexible fee policy for day-care services.

THE MENTALLY RETARDED CHILD; a guide to services of social agencies. Michael J. Begab. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 404. 1963. 134 pp. 45 cents.

Written as a guide for social work personnel in training and in practice, this publication focuses on the impact of retardation on the family and the social problems which inhibit the maximum development of the retarded child and threaten the stability of his family. It points to the variables to be considered in planning effective services for mentally retarded children and their families.

CLINICAL PROGRAMS FOR MENTALLY RETARDED CHILDREN; a listing. Rudolf P. Hormuth. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 36 pp. Single copies available from the Bureau without charge.

Listing by States 110 special clinical facilities for mentally retarded children, this publication is the fifth such compilation made by the Children's Bureau.

A GUIDE FOR PUBLIC HEALTH NURSES WORKING WITH MENTALLY RETARDED CHILDREN. Marian M. Holtgrewe. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1964. 49 pp. 25 cents.

Designed for public health nurses, this guide explains how the nurse can be an important liaison between the community she serves and its available resources in caring for the mentally retarded—and how she can provide help to the mother in management of the child in the home.

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◀

MOTHER AND CHILD in a well-child conference. The concentration of the doctor and the relaxed expression of the mother indicate that in this clinic time is allowed for attention to the individual needs of each mother and child. The importance of providing support to new mothers in areas where they are apt to have most concern is underscored in the article beginning on page 223.

Before joining the Children's Bureau staff in 1951, **Helen L. Witmer** was director of factfinding for the 1950 White House Conference on Children and Youth. For 2 years previously, she was research director for the Smith College School of Social Work. Among her many publications are reports of research relating to juvenile delinquency, children's emotional development, parent education, and adoption, including (as co-author) the recent "Independent Adoptions: A Follow-up Study," a report of the Children's Bureau study of adoptions in Florida.

Kazuye Kumabe was a medical social work consultant in the maternal and child health program of the Hawaii State Department of Health before joining the faculty of the School of Social Work, University of Hawaii, in 1963. She has also worked for the American Red Cross and for the Child and Family Service, a voluntary agency in Honolulu. She received her social work training at the University of Utah and at the University of Hawaii.

Educated in Europe and the United States, **Van Hromadka** holds degrees in the social sciences and social work. For more than 15 years he has concerned himself professionally with family relations and child guidance, both in direct service and scientific research—in California and Hawaii, and recently in his present position in New York. In Hawaii, he developed psychiatric and counseling services in the district courts of Honolulu.

A specialist in parent education who has written extensively for parents and for professional workers, **Aline B. Auerbach** was until recently assistant director of the Child Study Association of America, which she now serves as consultant. She has been instrumental in developing training programs in parent education for social workers, psychologists, guidance counselors, nursery school directors, and public health and maternity nurses.

For 4 years before joining the faculty of the Harvard School of Public Health, **Ruth Cowin** was a social worker at Children's Hospital Medical Center in Boston. From 1949–56, and during the 1963–64 academic year, she was a faculty member at the Boston University School of Social Work. She also serves as a board member of several community agencies concerned with family and child welfare services, homemaker service, and social work recruitment.

◀ *the authors*

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Some reflections on what we do and do not know about . . .

CHILDREN AND POVERTY

HELEN L. WITMER

Director, Division of Research
Children's Bureau

THE PURPOSE of this brief report is to present some facts about poverty as it affects children and youth in the United States today, in the particular hope that this information may be of use to those who are involved in planning community programs. Three main points will be considered:

1. What is meant by poverty and to what extent does the overall amount of poverty depend on the sort of measuring rod that is used?

2. How many and what proportion of the Nation's children and youth are growing up in poverty?

3. Where, geographically and socially, are these children of the poor to be found?

The third point is of especial importance, for by this information the nature of present-day poverty as it affects American children is suggested and some clues are given as to where an attack on poverty can be made.

How Poor Is "Poor"?

Poverty is currently defined by reference to cost-of-living budgets, attempts being made to identify annual income figures that mark the minimum required to meet basic needs at an "economy" level.

The figure most frequently cited as marking the poverty line in the United States today is an annual income of $3,000 for a family. This is the figure used in the 1964 "Economic Report of the President," prepared by the Council of Economic Advisers,[1] and in most of the subsequent publicity on the subject. The figure refers to annual money income before taxes are paid, expressed in terms of 1962 prices. It amounts to an income of less than $60 a week.

In seeking a cutoff point for poverty, the Council reviewed a number of studies of the cost of maintaining families at various levels of living, citing specifically one made recently by the Social Security Administration. The figure that was chosen was close to that study's estimate ($3,195) of the cost of an "economy-plan" budget for a nonfarm family of four. This budget assumes that such a family would have to spend a third of its income on food—$5 a person a week. If rent cost $800 a year (about $65 a month), the family would have $25 a week left for clothing, medical care, recreation, and all other purposes.

Objections to this definition are easy to make. Many families consist of more than four persons, and many consist of less. Some families live on farms and others live in small towns in which costs may be lower than this budget assumes. "Money income" is not all the income some families receive; some get income in kind and in other nonmoney forms. The Council was well aware of these deficiencies but found the use of a single figure necessary for its purpose of "assessing the dimensions of the task of eliminating poverty, setting broad goals of policy, and measuring our past and future progress toward its accomplishment." [1]

Several other ways of determining the line that separates "the poor" from the rest of the population have been suggested in studies published in recent years. One of these meets the objection that nonmoney income should be included. Another takes account not only of that objection but also of the one relating to size and composition of families. A third uses Federal income tax standards as the basis of estimate. Each—not unexpectedly—arrives at a different income figure for defining poverty.

The first of these studies is the one made by the Conference on Economic Progress.[2] Here the poverty line was drawn at $4,000 in "disposable income" for families and $2,000 for unattached individuals. (The President's Council considered $1,500 the cutoff point for unattached individuals.) These figures refer not only to money income but also to nonmoney income, such as the money value of food and fuel produced by farm families, wages received in kind, and the rental value of owner-occupied homes.

The writers of the Conference report based their selection of the $4,000 level on studies of workers' family budgets conducted in 1959 by the Bureau of Labor Statistics in 20 American cities. These studies showed that, in 1960 dollars, a "modest but adequate budget" cost a three-person family from about $4,500 to $6,300 a year, while for a six-person family the cost varied from $6,100 to $9,400. Assuming that $6,000 would be the average cost of this sort of budget, the investigators decided that it was reasonable to reduce that figure by a third, apply it to all families, and call the resulting $4,000 figure the poverty line. Such a figure, they pointed out, makes generous allowances for variations in cost from place to place and for variations in family size.

The second study—one that takes account both of nonmoney income and of size and composition of family—was made by a team of social economists headed by James N. Morgan of the University of Michigan's Institute for Social Research.[3] The investigators started from the minimum family budget figures worked out by the Community Council of Greater New York in 1959. This is a scheme that takes account of age and sex of family members in relation to their need for food, clothing, and other items.

Using these budgets as a standard, the Michigan investigators called those families poor whose "disposable" income (money and nonmoney) covered less than 90 percent of their minimum budget requirements and who had less than $5,000 in liquid assets. According to this way of calculating, a family consisting of an employed father, a mother, and 2 children aged 8 and 11 needed an income of at least $4,330 a year for minimum maintenance in New York City. Other families required proportionately more or less. In cities other than New York the poverty line might be set at as much as 20 percent lower, the study reports.

A third way of determining the poverty line is reported in a recent publication of the Social Security Administration.[4] It employs, as a very conservative definition of poverty, the lower limit for Federal income taxation used by the law that was in force in 1963. Such a definition calls a two-person family poor that has less than $1,325 in money income, while a family that consists of six persons would be poor if its income were less than $4,000.

By these various calculations, then, the poverty level for families has been set at a $3,000 annual money income, a $4,000 annual money and nonmoney income, and an income of varying size depending on the number of family members. What is the effect of these different ways of counting the poor on the overall estimate of the size of the poverty problem in the United States today? Perhaps surprisingly, the answer is "very little," as the following figures show.

How Many Are Poor?

When the $3,000 money-income figure is used as the cutoff point, Bureau of the Census reports show that about 9.3 of the 47 million families in the United States were living in poverty in 1962—20 percent of the total. The corresponding proportions in the 3 preceding years were 21 or 22 percent.

When the level is raised to $4,000 and both money and nonmoney income are counted, the figures of the Office of Business Economics, U.S. Department of Commerce (used in the study made by the Conference on Economic Progress) show the proportion of poor ranging from 20 percent in 1959 to 17 percent in 1962. When allowance is made for variation in size and composition of the family, the estimate based on the University of Michigan's survey in 1959 showed one-fifth of American families living in poverty. Approximately the same proportion was found by the Social Security Administration's investigator who used income tax levels as the basis of her estimates for 1959. Apparently, then, no matter which of these various methods is used, the often cited statement that in the early sixties about 20 percent of American families were living in poverty is correct.

This similarity in proportions is attributable to the canceling-out effect of the differences in the criteria used. An example will show how this can come about. Take a family with $2,500 in money income:

FAMILIES WITH OWN CHILDREN, 1960

By Various Categories; Proportion of Each Classified as Poor*

[In thousands]

Families	Head	Residence	Region	Total	Poor
All Families With Own Children				25,661	4,278 (17%)
White Families				23,263	3,154 (14%)
White Families	Male head			21,869	2,364 (11%)
White Families	Male head	Urban		15,043	953 (6%)
White Families	Male head	Urban	South	3,571	370 (10%)
White Families	Male head	Urban	Non-South	11,472	583 (5%)
White Families	Male head	Rural		6,826	1,411 (21%)
White Families	Male head	Rural	South	2,509	741 (30%)
White Families	Male head	Rural	Non-South	4,317	670 (16%)
White Families	Female head			1,394	790 (57%)
White Families	Female head	Urban		1,085	580 (53%)
White Families	Female head	Urban	South	278	163 (59%)
White Families	Female head	Urban	Non-South	807	417 (52%)
White Families	Female head	Rural		309	210 (68%)
White Families	Female head	Rural	South	134	100 (75%)
White Families	Female head	Rural	Non-South	175	110 (63%)
Nonwhite Families				2,398	1,124 (47%)
Nonwhite Families	Male head			1,901	723 (38%)
Nonwhite Families	Male head	Urban		1,388	374 (27%)
Nonwhite Families	Male head	Urban	South	589	240 (41%)
Nonwhite Families	Male head	Urban	Non-South	799	134 (17%)
Nonwhite Families	Male head	Rural		513	349 (68%)
Nonwhite Families	Male head	Rural	South	433	319 (74%)
Nonwhite Families	Male head	Rural	Non-South	80	30 (38%)
Nonwhite Families	Female head			497	401 (81%)
Nonwhite Families	Female head	Urban		413	326 (79%)
Nonwhite Families	Female head	Urban	South	182	156 (86%)
Nonwhite Families	Female head	Urban	Non-South	231	170 (74%)
Nonwhite Families	Female head	Rural		84	75 (89%)
Nonwhite Families	Female head	Rural	South	73	66 (90%)
Nonwhite Families	Female head	Rural	Non-South	11	9 (82%)

*U.S. Census: 1960, PC (1) D. U.S. volume, Table 225; State volume, Table 140. "Poor" is defined as less than $3,000 in money income in 1959.

This family would be classified as poor according to the $3,000 definition whether or not it also had nonmoney income. However, when the poverty line is drawn at $4,000 and nonmoney income is included, this family would not be counted as poor if it had an additional $1,500 income from nonmoney sources. At the same time, a family with a money income of $3,999 and no nonmoney income would be called poor by the latter way of reckoning, although it would not be poor by the $3,000 money-income standard.

Similarly, when account is taken of size of family, some large families are counted as poor whose money income is over $3,000 and some very small ones are considered not poor whose income is under that figure. In other words, each method of determining who is poor includes more of some kinds of families and fewer of other kinds as compared with the other methods. Thus the overall proportion of poor families can be about the same no matter which method is used.

This finding justifies the use of the $3,000 cutoff point for overall purposes—for determining the national total of poor families, for instance, and for noting changes in that number from year to year, the value of money being held constant. The $3,000 cutoff point is not adequate for all purposes, however. For instance, in local planning, when choices have to be made as to what kind and amount of services are to be provided and which families and individuals are to be served, this criterion may be an inadequate guide. More important for our present purpose, the $3,000 figure is quite inadequate for determining the total number of children who are growing up in poverty.

To settle, however, for any particular income figure as providing an indication of the living standard of the American poor today is to dull one's conception of the severity of the poverty problem. This is because the figure is apt to be taken to imply that most families classified as poor have an income close to the specified amount. The true situation is much worse than any of these poverty-line figures suggest.

No matter at which of these income levels the line is drawn, many families have incomes far below it. For instance, many more families had less than $2,000 in money income in 1962 than had up to $1,000 or more. Even worse, a fifth of the families below the $3,000 level had less than $1,000 a year in cash to live on. Far from $3,000 or $4,000 being close to the usual income of families that are called poor, considerably over half of them did not come within $1,000 of these figures. And within that proportion, a third to a half of the families were another $1,000 below the poverty line.

The answer, then, to the question "How poor is poor?" is "Very poor indeed." In the statements about the income of the poor—under $3,000, under $4,000, etc.—the emphasis should be on *under*. Many families and individuals are very much under the poverty line.

Clearly, in this era of affluence and rapid technological change, with jobs for the poor growing scarcer and scarcer, poverty is a major national problem. It is especially a problem for and with respect to the children of the poor. Change for the better, for all the Nation, depends particularly on the poor children's lot in life being greatly improved. Accordingly, it is to an analysis of these numbers and of certain characteristics of the children and their families that the rest of this report is devoted.

Children of the Poor

To say that about 20 percent of all American families are poor gives no indication of how many children are growing up in the handicapping condition that poverty implies. This is not only because not all families contain children and because poor families are apt to have more children than the average; it is also because the $3,000 poverty-line figure is itself a sort of average, and one that does injustice to large families. To discover how many children are being reared in poverty we must therefore consider not only the census figures but also the calculation of the poverty line itself. In doing so, we shall rely on the analysis made by Mollie Orshansky [5] of the situation in 1961. She is now in the process of making a more refined analysis, based on 1963 income figures.[6]

Not all families with incomes under $3,000 contain children. Of the 46.3 million families in the United States at the time 1961 income was ascertained, 18.7 million contained no children under 18 related to the adults; 27.6 million contained such children. In 26.2 million of the latter, the children were the families' own; in 1.4 million families, the children were related to the adults but were not their own. In other words, 60 percent of all families contained children who were related to them; 57 percent contained children who were their own. In much of the following discussion we shall confine our remarks to families with their own children, for the economic situation of children who are members of sub-families (those who live with one or both parents in families headed by other relatives) and those who are parentless and wholly supported by relatives is more difficult to determine.

Now, how many of these families with children had less than $3,000 in money income? Twenty-one percent of all families had incomes under $3,000 in 1961. Families with own children fared somewhat better—among them the proportion with incomes under $3,000 was 16 percent. Families with related but not own children were much worse off, 36 percent of them having incomes under $3,000.

In numbers, this means that 4.2 million families with own children were living in poverty. In addition, there were about 500,000 families with related but not own children in that situation, making a total of 4.7 million families who had insufficient income to provide adequately for their children's needs. Such families constituted slightly less than half of all families that were poor in 1961.

How many children does this involve, and what proportion of the total child population? This might seem a simple question to answer, since the Bureau of the Census reports show the proportion of families with various numbers of related children having various amounts of money income. In fact, using this information, the President's Council of Economic Advisers reported that the children of the poor numbered about 11 million in 1962—one-sixth of the population under 18 years of age. Consideration of the method by which this disturbingly large figure was arrived at suggests that it considerably underestimates the size of the problem. That this is so was stated by Walter Heller, the author of the Council's report, in recent testimony before a congressional committee.[7] To explain why this is so we must go back to the question of how the $3,000 poverty-line figure was arrived at.

It will be recalled that $3,000 was chosen to mark the poverty line because various studies showed this to be about the cost of a minimum budget for an average urban American family, consisting of husband, wife, and two children. This use of what amounts to an average income figure yields a satisfactory answer so far as families are concerned, because the greater budgetary needs of large families are counterbalanced by the smaller requirements of one-child families. When *children* rather than families are the unit of count, however, this averaging-out no longer works. This is because the $3,000 ceiling excludes some large families whose minimum needs come to more than $3,000 and includes some very small ones whose minimum needs are a bit below that figure.

The extent of the error is seen when the estimate of the number of poor children based on the $3,000 standard is compared with the estimate made by Orshansky,[5] who devised a poverty line that rose as the size of the family increased. The minimum budget figure for a family of four that she used ($3,195) is the one cited in the report of the President's Council of Economic Advisers in justifying the $3,000 figure.

In calculating minimum budgets, Orshansky started from the proposition that the proportion of income that must be spent on food is a good indicator of standard of living. To this she joined the finding of recent studies that, on the average, both farm and urban families in the United States spend about a third of their income on food. Then, taking the U.S. Department of Agriculture low-cost food plan as a guide, she estimated the cost of food for families of each size, taking into account their composition with respect to adults and children. Food costs for farm families were assumed to be 60 percent of those of nonfarm families, this judgment being based on recent studies made by the U.S. Department of Agriculture. The resulting figures were then reduced 20 percent to represent the cost of an "economy" rather than a "low-cost" food budget. For calculating total minimum budgets, these food-cost budgets were tripled.

By such calculations, Orshansky found that 18 percent of all families with own children under 18 were living in poverty—4.8 million families in all. This is sufficiently close to the number of such families that had incomes of less than $3,000 (4.6 million) to justify the claim that essentially the same degree of poverty was being measured by the two methods.

Counting the number of own children in these poor families, Orshansky found that they numbered about 15,859,000. To these she added an estimate of the number of children who lived in families headed by relatives who were not their parents and who were equally poor. The resulting total for children living in poverty was about 17 million—a figure more than

Children such as these are behind the statistics which show that nearly a fourth of the Nation's children live in poverty—in rural and urban areas in every region of the country.

half again as high as the 11 million estimate commonly cited.

This is a crude count, to be sure, but on the basis of this estimate it appears that in 1961 about a fourth of all American children were growing up in families whose incomes were clearly inadequate to meet their basic needs. Three million of these 17 million children belonged to families whose income was under $1,000 a year. Today the number and proportion of poor children may be somewhat smaller, for the most recent sample survey of the Bureau of the Census shows that the overall proportion of poor *families* has dropped nearly 3 percentage points since 1961 and is now 18.5 percent. Even so, there is little doubt 11 million is still much too low a figure.

Who the Poor Children Are

With poverty handicapping the development of so many children, it becomes most important to know who these children are and where they live. Detailed information on these points may suggest where some of the major attacks on poverty as it affects children had best be made.

Unfortunately, up-to-date figures about families and children, broken down into all the useful groups, are not available. For the most part, the best we can do in tracing the children is to use the figures from the 1960 census that deal with the income and certain related traits of families with own children.

The family characteristics on which the 1960 census volumes report in relation to income are race, type of family, and residence—both geographical and urban-rural. In combination with income, family figures based on these traits show rather well where poverty among children was—and doubtless still is—concentrated.

The figures on these points are shown in the chart on page 209. It should be noted that, of necessity, the under-$3,000 standard for poverty was used, instead of the standard more adequate for our purpose that was developed by Orshansky. Then, too, since the chart refers to *families* rather than to children, the percentages shown in it are not strictly applicable to the child population. However, the percentages are probably sufficiently accurate to indicate the relative size of the poverty problem among groups of children in our society.

A chart as detailed as this one can be read in many more ways than can be pointed out in the space of this article. Of major importance, however, is the fact that each of these main family characteristics sharply differentiates one group of families in the population from that with which it is contrasted.

First, in respect to race, in 1960 the proportion of nonwhite families that were poor (47 percent) was more than three times as great as the proportion of white families that were poor (14 percent). Since nonwhite families are apt to have more children per family, the difference between those proportions would be even greater if children instead of families had been counted. The difference is reversed, however, when actual numbers are considered, because of the fact that in the whole population there were 10 times as many white as nonwhite families. Thus, white families that were poor were almost three times as numerous as poor nonwhite families.

Second, in respect to type of family, the financial disadvantage to children in families headed by women is extreme. Sixty-three percent of these families were poor as compared with 13 percent of those headed by men. But, again, in actual numbers the situation is reversed, with 3 million families headed by men being poor as contrasted with slightly over 1 million families headed by women.

Third, rural residence considerably increases the chance of a family's being poor: 26 percent of the rural families were poor as compared with 11 percent of those living in urban areas. However, the actual number of poor families was about the same regardless of place of residence, being about 2 million in each case.

Fourth, living in the South also increases the likelihood of poverty. Thirty percent of Southern families were poor as contrasted with 11 percent in the rest of the country. In this case the actual number of poor families was about the same in the two groups, about 2 million in each case.

As would be expected, a piling up of disadvantages increases the likelihood of poverty—so much so, indeed, that in the most disadvantaged group in 1960, 90 percent of the families were poor as contrasted with 5 percent of the most advantaged group. In detail, the situation was as follows. When to a family's disadvantage of belonging to a nonwhite race was added the disadvantage of having the chief wage earner a woman, the likelihood of poverty rose from 47 percent to 81 percent. The likelihood of poverty was further increased by rural residence (89 percent of such families were poor) and even more (raising the proportion to 90 percent) by rural residence in the South.

When advantages rather than disadvantages pile up the opposite is true. Fourteen percent of all white families with own children were poor in 1960. When these families had a male head the proportion of poor dropped to 11 percent. When, in addition, such families lived in an urban area, only 6 percent were poor. And when the urban area was one that was outside the South, the proportion of poor families dropped to 5 percent.

Many more comparisons could be drawn from the chart, especially if combinations in addition to the particular ones shown there were made, but the comparison cited here may be sufficient to highlight three points:

1. The frequently quoted figure, 20 percent, which indicates the overall amount of poverty in the United States, is an average that is of rather little use for specific local planning purposes.

2. There are easily identifiable categories of children in which large proportions are growing up in poverty.

3. There are other categories in which the proportion of children living in poverty is low but in which the total number of poor children is nevertheless great.

Implications for Planning

Planning for the reduction of poverty should take both the proportions and the absolute numbers of the poor into account. In pinpointing the reasons for the existence of poverty the proportions provide the best leads. After these leads are followed, the importance of the absolute numbers comes into play.

When the proportion of poor families in a category is large, it is evident that there is something about the category itself that predisposes to low income. What this is may be fairly well known—for instance, in the category, nonwhite, and the category, female head. The disadvantages of families belonging to these categories are additionally confirmed by the Bureau of the Census reports which show that most families in these categories who are not below the poverty line are nevertheless very near to it.

When the proportion of poverty-stricken families in a category is relatively small, clues to what causes the poverty in which the children live probably are not to be found in conditions relevant to the whole category but must be sought in other factors that differentiate the poor families in the category from the great majority who are at least reasonably well off. This would be the case with the large category, white race, especially in the also large subcategory, white race and male family head, in which in 1960 only 5 percent of the 11.5 million families were poor. In these categories the process of analysis should be carried further, until subcategories containing large proportions of poor families are found. In these significant subcategories, then, clues to what needs to be altered in the families' situations would probably be found.

After the categories and subcategories of families that have a high incidence of poverty are identified, it is obviously worthwhile to know how many poor families there are in each of them. In addition, the actual income distribution within these identified categories would be a most useful item of information for planning, for this would indicate how poor the poor families really are, how much worse off they are than others in the category, and how many families only slightly above the poverty line should be reached lest they soon be added to the number of the poor.

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[1] Council of Economic Advisers: Economic report of the President together with the annual report of the Council of Economic Advisers. Washington, D.C., 1964.

[2] Conference on Economic Progress: Poverty and deprivation in the United States. Washington, D.C., 1962.

[3] Morgan, James N. et al.: Income and welfare in the United States. McGraw-Hill Book Co., New York. 1962.

[4] Epstein, Lenore: Unmet need in a land of abundance. *Social Security Bulletin,* May 1963.

[5] Orshansky, Mollie: Children of the poor. *Social Security Bulletin,* July 1963.

[6] ———: Counting up the poor. Scheduled for *Social Security Bulletin,* January 1965.

[7] House of Representatives, Part I: Economic Opportunity Act of 1964. Hearings before the Subcommittee on the War on Poverty Program of the Committee on Education and Labor. Washington, D.C., 1964.

It is not the point that the deserted mother in the slum may have somewhat better nutrition and less arthritis than an Asiatic rice worker. What counts is that somehow she is far adrift of what is expected in our society.

George James, M. D., New York City Commissioner of Health, to the 1964 meeting of the American Public Health Association.

In Hawaii high-risk maternity cases are brought into care through . . .

A PRENATAL CLINIC IN A RURAL AREA

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THREE YEARS AGO the Hawaii State Department of Health, through its branch of maternal and child health services, opened a prenatal clinic in a rural area outside of Honolulu. We believe our experience with this clinic offers many lessons for reaching pregnant women of disadvantaged populations with early and continuing prenatal care.

For several years the department had worried about the failure of a group of women living in a rural community in the outskirts of Honolulu to receive adequate prenatal care. Most of the women were of Hawaiian or Part-Hawaiian ancestry and were indigent or medically indigent. Urban redevelopment in Honolulu had forced their families to move into the country where housing was cheap. The distance from the city and the lack of public transportation discouraged their attendance at hospital outpatient clinics in the city except in emergencies. Serious and complex economic problems further interfered with any motivation they might have had to avail themselves of distant prenatal care.

These women were known to have many health problems other than those associated with pregnancy—for example, hearing impairments and dental caries were common. The birth rate among them was high. The public health nurses' caseloads of prenatal patients had increased threefold within a 3-year period. Such needs were behind the opening of the neighborhood prenatal clinic.

The clinic's major objectives were: (1) to provide more readily available prenatal care and post-partum followup services for a rural population with high birth rate and many socioeconomic problems; (2) to educate the women in the area to the importance of early and continuous prenatal care in achieving a favorable outcome of pregnancy; and (3) to coordinate the efforts of the health department staff workers in the area to promote the optimum physical and emotional well-being of the expectant mothers.

To make possible the intensive, individualized care regarded as important for the attainment of these objectives, attendance was initially limited to 10, and later to 15, patients per clinic session. "High-risk" patients were selected from the public health nurses' caseloads according to established priorities—women pregnant out of wedlock, women not under medical supervision, women showing evidence of physical complications, emotionally disturbed women, those with unstable family situations, and so on.[1]

A team consisting of obstetrician, public health nurse, practical nurse, nutritionist, and medical social worker staffed the weekly clinic sessions on Wednesday mornings.

Reaching the Patients

A review of the characteristics of the clinic patients reflected all those socioeconomic factors which various studies have pointed up as deterrents to early prenatal care.[2, 3] Among the 36 patients admitted during the first year, two-thirds were dependent on public assistance. Almost all came from families with occupational skills and little education. Fourteen were pregnant out of wedlock.

Thirty-one of the 36 patients were of mixed Hawaiian and other ancestry (Japanese, Chinese, or European), an ethnic composition known in Hawaii as Part-Hawaiian. Although it comprises only 17 percent of the State's 1960 population, this ethnic group has a higher birth rate and a higher infant mortality than does the State as a whole. It also has a disproportionately high rate of social breakdown. In 1959 it accounted for 51 percent of all illegitimate births. Its school dropout rate was the highest of any racial group in the islands, with only 5 percent completing high school.[4]

When the clinic was opened many persons in the community—including some health and welfare workers—were pessimistic about its chances for success, feeling that the combination of apathy, characteristic of many Part-Hawaiians, complicated by the many problems faced by a depressed socioeconomic group would make an insurmountable barrier to their use of clinic services. However, the medical director of the Department's Maternal and Child Health Services Branch was convinced that the expectant mothers in the community could use the clinic's services if means could be found to reach them.

The nature of the clinic provided a few built-in advantages for reaching and keeping the patients:

1. The location. The fact that "they" (the authorities) had cared enough about the women in the neighborhood to take the clinic out to them made a tremendous impression on these women. It seemed to stimulate a feeling of pride on "our" clinic. Many of the early patients made such remarks as: "You mean you folks come all the way from town, *just for us!*"

The proximity of the clinic to their homes also solved many of the practical problems which kept these women from attending clinics in town, such as the problems of transportation, baby sitters, and long hours of waiting. Many of the women could now walk to the clinic or could arrange for transportation or babysitting more readily since they did not have to go so far or be away for so long. Long periods of waiting—often interpreted as a personal affront[5] by clinic patients—have not been necessary.

2. Informality of the setting. The clinic's physical setting in a spacious public park beside a beautiful beach fostered an informal neighborly atmosphere—a sharp contrast to the crowded waiting rooms of a city hospital. The patients could sit comfortably outdoors on the lawn or in the lanai, an open covered area where they could socialize with their neighbors while the children could romp without close supervision. It was, as one patient put it, "like one big family"—a quality valued highly among Part-Hawaiians. The extended family system is still customary in this rural community as is the practice of informal placement of children with relatives and friends.

3. Continuity of individualized care. The patients had individualized care and continuity of care from the same obstetrician throughout their clinic experience. For many of them, this was the first time they had had the same doctor throughout their pregnancy or for any other health problem. For many it was probably also their first experience with a constant benevolent authority that could be both firm and warmly personal.

4. A cohesive professional team. The patients were served by a multidisciplinary staff whose members worked together as a cohesive and enthusiastic team.

The Methods

The staff recognized that new combinations or different ways of applying old methods and skills would be necessary for convincing these dependent and deprived women during their pregnancies—a time when they were more apt to be accessible to change—of the importance of regular prenatal care. Many of the women were skeptical about the value of such care, having come to regard pregnancy as a periodic nuisance to be tolerated. Many had built up resistance against the impersonalized practices of the hospital outpatient clinics.

The staff hoped that enveloping these women in an all-pervading atmosphere of giving, of warmth and acceptance would satisfy their personal needs enough to encourage them to come regularly to the clinic. The staff members realized that to provide such a milieu would demand sincerity, conviction, and unity of purpose on their part. The staff would have to be what Charles Hendry has described as "responsive and responsibly related to the felt needs of the people."[6]

To achieve the necessary teamwork weekly post-clinic staff conferences were held regularly. These were attended by the entire professional staff.

The maternity clinic team in a post-clinic conference. From left to right are the student social worker, medical social worker, obstetrician, nutritionist, and public health nurse.

Learning to work together as a cohesive unit required time and disciplined effort. The philosophy which each member brought to her role on the team, both as an individual and as a professional, had to be tested. In the beginning the patients' many problems, and their seeming lack of response to the staff's suggestions brought many expressions of discouragement. Some of the staff reacted rather subjectively to "uncooperative patients," who, they felt, were not appreciating the clinic services.

At these meetings the social worker pointed out the emotional and social factors in the situation of the patient under discussion in order to help the other team members see the patient as a whole and to relate to the healthy elements in her personality and environment. Growth was apparent among the team members as they began to understand and to look objectively at their own feelings of resistance to the recalcitrant patients. As team relationships matured the quality of each member's specialized contributions improved, and each was better able to assimilate the contributions of the other disciplines.

Because the nature of the patient's interaction differed with each team member, many facets of the patient's personality were revealed as the members reported their observations. As a result, a composite evaluation of the patient, derived from pooled information, gave the team an earlier and a truer picture of the whole individual than one member could have obtained alone.

Team functioning was also facilitated by the physical setting and the clinic's informal arrangement which fostered free communication and intermingling among the staff members and between staff and patients. The members of the various professional disciplines conducted individual interviews with their patients in different corners of the lanai, away from the group but still in a sense a part of it. This seemed to make it easier for the patients to leave the group for individual interviews.

During the clinic sessions the staff members frequently exchanged information informally and referred patients to a team member of another discipline for specific help. Sometimes when a team member had discussed information in an area overlapping another team member's field of competency she would ask the other staff member to join her in a joint conference with the patient. From these experiences the patients learned to differentiate the professional roles and to request services accordingly.

The staff tried especially to encourage camaraderie among the patients. New patients were introduced to the old, and outgoing patients were asked to help the reticent ones to feel that they were a part of the family. When a patient had her baby the other patients were told about it and about the condition of the mother and child.

With the gradual development of esprit de corps, the patients assumed more responsibility to help each other with problems, such as getting to and from the clinic. They would discuss their common problems together—the most popular subjects being weight control and too many unwanted pregnancies. Sometimes the nutritionist or social worker would join the group discussions. At times the mothers would call on one of the staff to clarify a point at issue. Some of the mothers exerted a positive influence in educating the other patients. For example, one mother urged the others to attend the clinic regularly because she herself had suffered complications at the birth of her fourth child for lack of prenatal care.

Another method employed in reaching these patients was to offer concrete services. Oriented to the present, these women could understand and assimilate help which met their immediate needs more easily than they could the intangibles of counseling alone. Foremost among the concrete services, of course, was the high quality comprehensive medical and nursing care they received. There were, however, other concrete services. To bring reality to her counseling, the nutritionist served powdered milk to demonstrate that it could be both tasty and economical. Baby clothing and supplies obtained from volunteer donors through the Department's Health Education

Branch were given to mothers needing them. When photographs were taken for the record, the women were given copies of snapshot size. Notes confirming their pregnancy were given to the patients who were public assistance clients to show that they qualified for additional dietary allowances.

Every opportunity was used to help these women see that the clinic's services were given to them because of their individual worth. Husbands who came to the clinic were drawn into individual and joint counseling to help them understand and meet the wives' needs. By meeting the personal needs of the expectant mothers and raising their self-esteem, the clinic staff hoped to help them increase their capacity to give themselves emotionally to their children.

Some Results

Almost one-third of the clinic population during its first year were teenaged primigravidae. Some of these girls gave evidence of marked changes in personality and behavior after their clinic experience. Perhaps the emotional and physical changes brought about by the combined factors of pregnancy and adolescent development made them more susceptible than the older women to such modification. Leilani Makaiwa (not her real name) provides a good illustration. A 17-year-old Part-Hawaiian primigravida, Leilani had married a widower 30 years older than herself in order to escape from a mother who had been using her "to get money from the boys." Her sister, who was also attending the clinic, was married to a man 41 years her senior.

During the early months of clinic contact Leilani behaved like a bump on a log. The team members felt defeated over her apparently limited mentality, her passive childish manner, and her lack of responsiveness. She seemed like a little lost child who could not fully comprehend the change in her status and the responsibilities of marriage and pregnancy. Her apparent inability to communicate seemed related to early severe emotional and social deprivation and a lack of satisfactory parental figures with whom to identify.

The need to move slowly with Leilani at her own pace was both frustrating and challenging to the team members. The nurse and nutritionist counseled her mainly through her husband. A protective, fatherly man, he had taken responsibility for the household management and was teaching his young wife how to cook, plan menus, market, and so on. In postclinic conferences the staff came to see that the dual roles of husband and father played by Mr. Makaiwa seemed to be fulfilling many of Leilani's unmet psychosocial needs. Recognizing the strengths in this May-December relationship, the staff decided to support Mr. Makaiwa in helping Leilani to grow.

The public health nurse continued to counsel Mr. and Mrs. Makaiwa together regarding the changes of pregnancy, giving simple repetitive explanations with the use of pictures and charts. The nutritionist doggedly persisted in giving detailed diet instructions to the couple, who tried to keep on the track but faltered periodically. The medical social worker gave Leilani continuing emotional support through regular individual interviews.

Although Leilani remained passive after weeks of personalized attention from the physician and the rest of the clinic staff, her pregnancy and the clinic experience must have been satisfying to her, for she and her husband kept every appointment. About 4 months after her initial visit the public health nurse was startled one day to have Leilani cheerfully walk up to the conference table alone, motioning to her husband to remain in the background. She chatted amiably about herself and family events. Since that day there was a gradual and gratifying transformation in Leilani's appearance and manners. Not only did she become neater in appearance but she began to respond to people with a meaningful smile and to participate in plans for herself and the baby, even to the point of asking questions about her pregnancy. On several occasions she attended the clinic without her husband.

On the day that Leilani gave birth to a 6-pound

This "waiting room" of a prenatal clinic in a rural area outside Honolulu is a lanai overlooking the sea, thus offering a relaxing atmosphere for patients and their families.

3-ounce baby girl, her husband appeared proudly at the health center to announce the event. Two weeks later Mr. and Mrs. Makaiwa made a special trip to the clinic to "show off little Leilani" to the staff and to the other patients.

The warm accepting climate of the clinic and the constancy of the individual attention from each team member apparently had given Leilani a feeling of security and an increasing sense of self-worth, thus enabling her to grow. The individualized care and continuity of relationship provided by the same doctor in each clinic visit had given her a positive experience with an adult authoritative figure. With this kind of support Leilani had been helped to improve her level of functioning, thus increasing the possibility for her to become an adequate mother.

Followup Service

A program of comprehensive maternity care would not be complete without providing for continued service after the patient's discharge from the clinic. To insure that at least part of the gains made by the mothers could be sustained and carried over into their relationships with their children, the clinic worked closely with the public health nurses and the social agencies in the community. Changes occurring in some of the seemingly hopeless patients, like Leilani Makaiwa, encouraged the public assistance workers to reach out with intensive casework services to selected patients. A private casework agency in Honolulu, which serves destitute Hawaiian and Part-Hawaiian children, was so stimulated by the clinic's experiences that it extended its services to the same rural area and now has plans for expanding its activities there to include community development work.

The people who live in the community are showing increasing interest in the clinic because they can see the direct benefits to the women. Happy, satisfied patients have proved to be the best emissaries to the community and also the best generators of continued enthusiasm among the clinic staff. Such enthusiasm is important in sustaining the vitality of the team and its ability to continue to meet adequately the emotional and physical needs of the patients.

The patients have been continuing to respond to the concentration of consistent medical care and emotional support. More and more of them have been attending clinic regularly, many have not missed a single appointment, and returns on post-partum examinations have been increasing. In their previous pregnancies most of the patients had never returned to a clinic for a post-partum examination.

The experience of this demonstration prenatal clinic seems to bear out observations reported from a study carried out in the outpatient obstetrical clinic of the Yale University School of Medicine: "The primary needs of a maternity patient in the clinic situation are centered around those of (a) good physical care and (b) the need for adequate emotional support. . . . Those patients who consider that they are getting adequate emotional support are also those patients who most readily accept the fact that they are getting adequate technical care."[5]

Ego-supportive and ego-building techniques were essential elements in all our efforts to attract and hold our patients. We believe that resistant patients returned to us after their first skeptical visit because their personal needs were individualized and handled on a level which was understandable and meaningful to them. A decisive factor was the application of a highly integrated planned team approach. The experience demonstrates that deprived, socially inadequate groups will respond to service if their individual and group needs are perceived and identified accurately and if services are adapted creatively to their own felt needs.

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[1] Hawaii State Department of Health: Nanakuli Maternal Health Conference; maternal and child health service demonstration project. Honolulu. Feb. 28, 1963.

[2] Monahan, Howard B.; Spencer, Esther C.: Deterrents to prenatal care. *Children,* May–June 1962.

[3] Donabedian, Avedis; Rosenfield, Leonard S.: Some factors influencing prenatal care. *The New England Journal of Medicine,* July 6, 1961.

[4] Liliuokalani Trust Child Welfare Department: A survey of the socio-economic status of the Hawaiian people today; and A study of the characteristics of children under care of Liliuokalani Trust Child Welfare Department. Honolulu, Hawaii. August 1962.

[5] Schlesinger, Richard H.; Davis, Clarence D.: Patient, staff, and organizational needs in a clinic setting. *American Journal of Obstetrics and Gynecology,* Jan. 1, 1962.

[6] Hendry, Charles E.: Community organization teamwork in rural communities. *In* the social welfare forum, 1953: Proceedings of the National Conference of Social Work. Columbia University Press, New York. 1953.

HOW CHILD CARE WORKERS ARE TRAINED IN EUROPE

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PERSONS who work with children have long recognized that the child in institutional care can be helped to make a healthful adjustment to life by being treated as an individual and not just as a member of a group. The child has to be exposed to the benefits of group experience—but this group experience should not keep his individual psychosocial needs from being met.

This approach assumes that the child's total living experience should be therapeutic and, therefore, be planned and managed in the interest of his healthful adjustment. Child care workers, often called "cottage parents," "house parents," or "counselors," hold a key position in this new approach to care: They have the unique opportunity to observe the child in an informal setting in his hour-to-hour living experience.

With this approach has come the realization that child care staff usually lack the professional knowhow and status for the responsibilities they carry. As director of a research project to find ways of upgrading child care staff, I have found a growing awareness among institutional administrators of the importance of the child care worker's role.[1] Nevertheless, people coming into the field have extremely limited or no child care training. Moreover, the rivalry between so-called professional and nonprofessional workers is still strong. The efforts made in this country to remedy the situation are inadequate and lack a uniform approach. Most of the training is carried out through local inservice training programs or short-term extramural courses, seminars or workshops,[2] which usually deal mainly with a specific local emergency. Experiments in employing child care workers with professional training in some related discipline have had mixed results.

The situation is somewhat different in Europe—or at least in those European countries with the more advanced child care programs. Judging from my own research and from reports made to the United Nations, the International Union for Child Welfare, and the International Association of Child Care Workers, such countries would include Austria, Belgium, Denmark, England, France, Germany, Holland, Switzerland, Sweden, and Yugoslavia. Except for Belgium and Sweden, I have studied the approach to training of child care personnel at firsthand in all these countries and have found more similarities than differences among the various systems both in philosophy and practice. In this article when I speak of Europe and European ways I am referring to these countries.

The first thing that impressed me in Europe was the cohesiveness of staff in those child care institutions which had an interdisciplinary team. The representatives of the various professional disciplines seemed like a homogeneous group; they spoke to each other on equal terms and respected each other. In explanation, I found that: (1) most of the psychologists, psychiatrists, social workers, and teachers on these teams had some direct experience in taking care of children in institutions, or, in addition to their original professional training, they underwent the same training courses as the child care workers; and (2) most workers who took direct care of children were graduates of comprehensive training programs in child care which were never less than 2 years in duration.

The other difference I noted between practices here and in Europe relates to the overall scope and concept of child care. While in this country we tend to emphasize services to children who are physically or emotionally handicapped, in European countries there seemed to be much less differentiation between types of children for whom services were provided and a greater emphasis on giving equal importance to all children. This emphasis dates from World War II, when Europe was confronted with the problems of evacuation, mass mobility, and the care of children separated from their families. Europe was unprepared for this task and had to use every human resource available and make many improvisations. Inexperienced workers shared the burden with experienced workers; both learned a great deal from each other. In this process, newly recognized or discovered methods, tools, work habits, and activities were found useful in the child's rehabilitation.

The empirical knowledge derived from the experimentation and research of World War II was used to develop the postwar child care programs and training. Two ideas particularly were emphasized:

1. ***A child is always a child, regardless of his personal handicap or living circumstances.*** He is never less than that—not a thing (a case), nor an animal, even when he acts like one. He is never more than that: he is not an adult, even when he acts like one. Therefore, child care programs and training for child care should be concerned with the normal child, taking into account, of course, the special needs of the handicapped child. The handicapped child's deviant ways should be understood and dealt with in close line with normality. Frequently, similarities rather than differences should guide the rehabilitative process. A handicapped child should not be treated as an oddity or freak, but as a child. The range of activities for the handicapped child should be broadened, not limited, to include truly stimulating, creative, and useful activities—meaningful for all children. (Often in this country special activities arranged for handicapped children seem planned more for the worker's than the child's convenience.)

2. ***Residential care and care outside the residence should be treated equally.*** The basic training for child care workers in either area should encompass most of the same knowledge and skills. Similarities rather than differences guide the shaping of a program structure. Unless the worker is trained thoroughly in child care, he is not adequately prepared for work with children, within an institution or outside as a street worker or parent counselor.

European Programs

These two ideas are generally accepted by all the European programs I have studied. Their training efforts usually have the following pattern:

1. Both fieldworker (who works with children and youth and their parents in the community) and residential worker in schools or child care institutions take the same basic training averaging about 2 years. A specialized course follows for persons who choose to work with severely handicapped and delinquent children. An advanced course produces the child care specialists and also trains for teaching, administration, and research. In some countries these training steps are handled in different schools; in some, they are all parts of one program.

2. Many subjects taught correspond with material presented in training programs in this country, but there are four areas of wide difference:

- The degree of emphasis on teaching child care workers how to observe a child and how to learn from observation. European training could not put more stress on this than it does now. Most of our training programs for child care workers barely touch the subject, if at all.
- The stress put on creative and activity therapy. The emphasis is not so much on developing the worker's skills or know-how in leisure time or vocational activities as on appreciation, understanding, and the therapeutic use of creativity and various forms of human expression and communication. One French school devotes a whole semester to teaching the child care workers how to appreciate modern art. What we in the United States do in this regard varies: Too often we have a lecture on activity, list games to keep "kids" busy, or suggest traditional needlework, wood or metal work for rainy days.
- The emphasis on teaching "pedagogy" and "defectology" in European programs. A course in "pedagogy" instructs workers in how to handle the child in various situations and to help him learn new knowledge and build new standards and values. Courses in "defectology" teach methods of handling children who are afflicted with mental or physical impairments.
- The emphasis in Europe is on the child care worker's personality development, so that he can make use of the knowledge he has acquired. Talking about love and affection is not enough. Real understanding comes when workers are convinced of the fundamental goodness of human beings, when they are prepared for disappointments, and when their ability to give and receive love is increased. To meet this goal, the prospective child care worker is, first of all, carefully screened before he is enrolled as a regular student. While in training, he is required to live with other students and is sub-

jected to experiences in group dynamics. His adjustment and growth are continuously evaluated and discussed with him. In some schools the student is also expected to subject himself to personal analysis or psychotherapy, which is available to him for a nominal fee. The short training courses provided for institutional workers in this country can hardly include these provisions.

Child Care Worker's Status

The graduates who complete all phases of such European programs are considered professionals with all the privileges. In an institution for delinquents outside Paris, I saw a staff composed entirely of such graduates in action. In full charge of their living units, they also functioned as caseworkers, group workers, and group therapists, and maintained contact with the community and family. All child care workers, working as a team on an equal basis, were directly responsible to the director, himself a senior child care worker. The position of supervisor in our sense was unknown. The staff held daily consultations and received consultation from a psychiatrist. Also, they had an analyst, a psychologist-therapist, available to them whenever they felt they had a personal problem that might affect their work—or when they felt the pressures of work might affect their personal lives. The exchange between analyst and his worker-clients was confidential.

The multiple functions and professional status of child care workers in this institution are not, of course, typical. Other institutions in Europe have a true interdisciplinary team approach. Division of labor and interprofessional rivalry exist as they do here. But there are differences. In Europe a fully trained child care worker giving direct care feels much more accepted than he does here: (1) because he does not compete with the social worker, whose function is less broad there than here and who less frequently carries the therapist's responsibility in a residential setting; and (2) because the European psychiatrist is differently oriented. At the administrative level, however, advanced child care workers are in pronounced competition with schoolmasters and educational psychologists, who, traditionally, have been in charge of schools for the handicapped and are not ready to see this changed. This competition, however, has an historical basis and does not imply lack of recognition of the child care worker's capability. In fact, schoolmasters and educational psychologists enroll in courses for child care workers.

From the foregoing, it would seem that the child care worker in Europe "has it made"—he gets thorough training, his contributions are recognized, and he enjoys status. This is not quite true. European workers are still striving toward complete professionalism and continue to scrutinize their training programs.

Goal of Training Programs

The European experts in the child care field see their child care training programs as helping to fashion a new profession, one at the juncture of nursing, social work, teaching, and psychiatry—drawing from these disciplines but evolving as an entity. They believe that new knowledge and concepts of child care remain to be discovered, and that there is need for research, experimentation with method, international exchange, and the development of a literature. They also believe that all the disciplines, unless supplemented by additional specialized training, do not qualify a person for residential work.

What should the training curriculum include? Many European experts seem to agree on these points:

1. *The central theme should be the development of the enrollee's personality.*

2. *There should be a constant connection between theoretical knowledge and its practical application.* The schools and institutions should work closely together in selecting the desired experience and in evaluating the student's progress. The institution, not the school, should supervise the student in placement. (As yet, however, institutions do not have trained supervisors to do this.)

3. *The curriculum should include the following courses* (in some countries it already does): (a) those which give knowledge about people, their environment, culture—psychology, social psychology, sociology, anthropology, ethics, medicine, and hygiene; (b) those which instruct in useful methods—pedagogy and defectology, case work and group work, nursing, homemaking routines, observation, diagnostic evaluation and treatment planning, reporting and recording; (c) those which relate to running an institution—social services, administration, budgeting, supervision and consultation, legislation, community work, research; and (d) those which develop appreciation of creative vocational and leisure-time activities for children.

For example, in art classes the enrollee learns not only to understand, appreciate, and teach art for its own sake, but also how to use it in life situations and other learning experiences. He also learns how to promote a child's interest in tools, materials, and various art forms and how to use art to stimulate interest in other school subjects—chemistry, through chemistry of pottery; history and geography, through history of foreign crafts; mathematics, through study of pattern designs. Classes in language development provide a clear understanding of the interactions between linguistic development, general mental development, and formation of attitudes toward life. Nature study teaches the worker how a child's urge to explore may be partly satisfied through the study of nature, and how to use environment in planning recreation.

4. ***Thorough training in psychology is needed, especially depth psychology.*** This training should have two aims: to enable the child care worker to look at himself; and to study the condition of others. There is, however, some recognition of the dangers of developing "pseudo-therapists" or of upsetting beginning workers with large doses of self-discovery. Many persons concerned with these training programs see child care workers as developing an ability to carry out supportive and developmental therapy, but not correctional therapy. As to teaching methods, European experts consider the traditional classroom lecture less effective than group discussions or demonstrations.

Selection of Students

In order not to discourage applicants, the European training programs seldom have specified educational requirements. However, applicants are usually expected to have a level of formal education that compares favorably with 2 years in an American college. To enroll in the basic course, no previous child care experience is usually required, but the applicant's attitudes and overall ability to work with children are assessed. This is done through a short placement in a child care institution where he works under close supervision and lives in a students' dormitory where his behavior in a group is observed. Persons enrolling in advanced courses are usually required to have 3 years' experience in residential care.

The applicant's personality and motivation for child care work are regarded as very important. European child care experts believe that no single method of screening applicants for training for child care work is reliable; that a combination of methods should always be used. Psychological testing, though used by some schools, does not seem popular. The combination of methods favored by most experts is: an application form designed to detect personality traits and attitudes; personal interview with at least two members of the admissions committee; and a pre-enrollment institutional placement.

Once selected, the student is continuously evaluated for academic learning, application of knowledge to practice work, and personality growth. Some schools give written tests or assignments; in most places, the student is evaluated on class participation alone. At the end of the advanced course, however, students are almost always required to write a paper.

In the countries I visited, the reported average age of students in the basic course is middle twenties; in the advanced course, middle thirties. The maximum age for enrollment is 45; the minimum is 18 for women, 24 for men, and 23 for women who wish to work with adolescents.

A Summing Up

At present, I have no way of evaluating completely the European approach to child care and comparing it with the general approach in this country. I cannot say which is better or more advanced. There are differences in philosophy and practice; there is some good and bad in both. There is no single blueprint for good child care. All we can do is experiment and learn from the experience of others—and we and they are doing it.

We are constantly searching for new ways to help children, particularly in residential treatment of emotionally disturbed and socially maladjusted children. The idea of developing a new kind of staff of child care practitioners is under study. It is imperative that a good program for their training be formulated.

I believe that the National Institute of Mental Health project, "Formulating Training Program for Child Care Personnel,"[1] is a very important step. However, much more must be done. Reassessing the entire child care program in this country and the philosophical reeducation of all concerned is also important. To do this, free of historical biases, we should try harder to regard child care not so much as a functional problem as an emotional and intellectual challenge. We should think of it not so much in terms of corrective therapy as in terms of restoration and reeducation of children toward more healthful living.

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[1] U.S. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health: Formulating training program for child care personnel. Project No. MH 631. (Sponsored jointly by the Jewish Board of Guardians, New York, and Teachers College of Columbia University.)

[2] Child Welfare League of America: Training courses for cottage parents. New York. November 1960.

Why alertness to the maternity patient's own concerns is important in . . .

MEETING THE NEEDS OF NEW MOTHERS

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WHAT ARE some of the outstanding psychological and social needs of new and expectant parents as they themselves see them? What has created these needs? And what implications do they have for health and welfare services and especially for the professions involved in maternal and child care?

Over the past 10 years participants in numerous discussion groups for expectant and new parents—of all socioeconomic backgrounds—have given the Child Study Association of America, a national voluntary agency concerned with parent education, a picture of the many needs of parents before and after their babies are born. Included in this picture are the exceptional needs derived from acute social situations, such as illegitimacy and extreme economic deprivation. But even more relevant for the professions concerned with maternal and child care are the less dramatic and more common psychological and social needs which are often overlooked. These are the needs with which this article will be concerned, for they too are deep and critical. They call for help to be given in many different ways and at different times as an essential part of comprehensive programs of maternal and child care.

The parent discussions out of which the picture of these needs emerged were carried on across the United States and in Puerto Rico in connection with leadership-training programs for nurses conducted by the Association under the sponsorship of the Children's Bureau, U.S. Department of Health, Education, and Welfare.[1]

The discussion groups have been conducted by means of guided group discussion without a formal curriculum plan. With the content of their training course highlighting findings of medicine, nursing, psychiatry, psychology, cultural anthropology, sociology, social work, and education, the nurse leaders have been alert to the psychological, emotional, and social aspects of maternity need as well as to physical needs. They have encouraged parents to share their ideas and feelings about their experience, add information where needed, and have helped them gain the broader understanding that will be useful in coping with the new and changing demands of parenthood.[2] At the same time they have learned about what the parents themselves regard as important and about what worries them most in regard to their parenthood. The following generalizations are derived from the nurses' reports and from observations of their group meetings.

Generally, young parents want education and guidance in their different personal and family roles—yet they live in an age in which knowledge about interpersonal and family relations is widespread, largely because of the mass media of communication.

Based on a paper presented at the 91st Annual Forum of the National Conference on Social Welfare, Los Angeles, Calif., May 28, 1964.

Why this apparent contradiction? Many young parents have indicated that intellectual generalizations have little meaning for them when they come up against a reality such as pregnancy. In the opening sessions of expectant-parent groups, both college graduates and parents of little education often say they want to know "about everything . . . about labor and delivery, when to go to the hospital, baby care, everything about the baby—how to make him comfortable and start him off in the right way." Increasingly, they are also saying: "I want to know about what fathers can and should do to help."

Psychological Unpreparedness

Yet, even fragmented exposure to ideas about child development, interpersonal and family interaction, and new medical knowledge has directed the thinking of many parents in other directions as well. They want to know about themselves, the nature of their reactions to pregnancy and whether it is "like other people's," their expectations of themselves during labor and in handling their new babies, the kind of baby they may expect, and what changes a baby will make in their relations with their husbands, their families and friends, and in their own daily lives. These mothers pour out confused and often contradictory statements of expectations and goals—revealing the extent of their psychological and emotional unpreparedness. Faced with what seems to them to be utterly new and unrelated to anything they have thought, felt, or experienced before, they are like children themselves. They want to carry out their parenthood properly but are not certain they will be able to do so.

Obviously, the relation of parents to the new baby can be greatly influenced by the comparative ease or tension with which they move through the antepartal period. Perhaps one can never fully understand such a tremendous, dramatic life experience until one lives through it. Doctors, nurses, social workers, and others can ease the tension of these young people by giving them factual information about what, realistically, they can expect of themselves and the baby. These young parents can also be helped to understand better their current day-by-day experiences, taking into account the interplay of physiological, psychological, and social factors.

With all their pseudo-sophistication about the physical "facts of life" and family relations, many young people today know surprisingly little about the subtler aspects of pregnancy, about flesh-and-blood babies, and the parent-child interplay. Social changes in family living have contributed to this lack of knowledge: early marriages, often before the young couples even know themselves; lack of exposure to infants and young children (due largely to the mobility that has taken many young people out of range of their own larger families); and the inability of many young people to turn to their own mothers for guidance, even when they are accessible—sometimes because they feel they must be independent at all costs, sometimes because they feel that their mothers are hopelessly behind the times. Sometimes their mothers share this feeling about themselves and hesitate to give their views about child care because they are uncertain about "the new ways." And so the lack of communication between the generations is increased and the value of some human experiences is lost.

There is another strange paradox: Along with their general lack of knowledge, expectant parents often have partial or inaccurate information or isolated facts that cause them to be anxious and uncertain—about themselves and their behavior, the coming baby, and the new life after the baby comes. As Gerald Caplan[3] says, these concerns are quite universal and tend to follow a pattern in sequence and intensity; they are also colored by a parent's life history, by new knowledge, or by new events.

Feelings and Fears

It is often difficult to separate the parents' feelings of insecurity about their new babies from feelings of insecurity about themselves. During pregnancy, especially first pregnancies, and the early post-partum period, these feelings are basically interrelated. The mothers' concerns about themselves take over in early pregnancy: their physical "symptoms" or discomforts, their ambivalent feeling when they first learn they are really pregnant, even when the pregnancy was planned and is much wanted; their changing moods and often uncharacteristic wish to be looked after like children. The professional persons helping mothers should recognize these concerns and aid mothers in understanding and taking them in stride. Then they will often move past their uneasiness about their own responses and begin to think more specifically about the baby.

Katherine M. Wolf[4] pointed out that the dependency needs characteristic of many expectant mothers result from complex forces coming from their previous life experiences and are activated by the immediacy of a new demand. She believed also that these needs might serve a unique purpose: If mothers receive the love and emotional support they crave at this time from husbands and families, they build a reserve to draw on later for their babies. Mothers seem to use this period for psychic preparation, marshaling new strengths that will help them during labor and delivery and in taking on the mother role.

But how does knowledge of the dependent, regressive behavior of women during this period influence the practice in prenatal services? What extra demands does this place on doctors and nurses, already overburdened and with barely time to listen to major complaints? How can clinic facilities be expanded to allow more time per patient? To what extent can clinic patients be assigned to one staff doctor for care and support throughout the pregnancy, as is being done in some teaching centers? Can more medical social workers be available routinely to help patients work out practical problems that often seem so overwhelming that they tend to increase these feelings of dependency? Can all clinical personnel be alerted to the special psychological needs of mothers and treat them with the consideration and respect they deserve? These questions demand attention.

Despite far lower maternal mortality rates and vast improvements in obstetrical practice, many mothers still carry with them the age-old fear of possible injury to themselves and even of death during delivery. Even expectant mothers trained as nurses sometimes express deep fear of "the valley of the shadow of death." In a recent training program, several nurses with grown children admitted they had carried this fear locked within them during pregnancy, as if the fear had ominous strength and in a magical way might cause them to die if they even put it into words. In retrospect, they recognized how much they would have been helped if they had talked out their fears, if they had known that other women with similar fears had come through without harm, and if they had been helped to look at their apprehensions more objectively.

Almost universally, fathers as well as mothers fear that the baby will be born in the car or taxi before they reach the hospital. *Then* what will they do? This is one practical problem on which they tend to pin their more generalized feelings of helplessness and insecurity. It needs to be met primarily at the factual level—its probability and the many ways in which people manage it, even under most difficult conditions. Knowing this, their anxiety is relieved to some extent. A more basic concern is: How will they behave during labor and delivery? Will they yell and scream and disgrace themselves? Will anesthesia, or partial anesthesia, make them lose control? Here, too, professional reassurance can help modify the stoic, almost puritanical expectations of women from some cultural groups. Many women are relieved to know that doctors and nurses understand and can "take" all kinds of behavior.

This emotional support is most critical. New mothers on a maternity floor recently pointed out that anticipatory guidance—help in knowing more of what to expect and what to do about it—had been helpful. But what had helped them most to go through pregnancy, labor, and delivery with a minimum of distress and anxiety had been the emotional support from nurses or doctors. They all reported that just knowing that someone was standing by made a vast difference. Unfortunately, the complicated machinery of hospital practice has not always provided manpower for such supportive service in the crisis of labor and delivery. The "natural childbirth" movement and its recent modifications, such as "psychoprophylaxis," have helped to refocus attention on the importance of emotional support during childbearing. Many obstetrical services are attempting to make the provision of such support a part of regular hospital procedure, but much needs to be done in training and administrative planning to make it an integral part of all maternity care.

Concerns About the Baby

Even in early pregnancy, the mothers' concerns about themselves are tied in with their fears about their babies. How are their babies developing in utero? Will they be "normal" and fully developed?

This subject comes up in discussion groups of expectant mothers everywhere. It reflects a universal concern of parents, probably one that has always been present to some degree, but recent events have accentuated its meaning. During the scare over the effects of thalidomide on early fetal development, mothers everywhere talked about their fear of physical anomalies. Today, they seem to focus more on the possibilities of brain damage and mental retardation, doubtless influenced by recent legislation and the current emphasis on both prevention and care of these disabilities.

As they talk, young mothers tend to link these conditions with inadequate medical care during pregnancy—to harmful medications, excess anesthesia, unidentified toxemias, hasty deliveries, even breech birth with possible oxygen loss to the baby. They often do not seem to recognize the possibility of genetic or constitutional factors and concentrate on external causes that new medical knowledge may be able to overcome and over which man may have some control.

The subject of deviations is complex. It is open to many misunderstandings and it arouses deep feelings in all of us. The persons serving families have to search out the best scientific knowledge. They need to face the possibility of deviations in the newborn and be honest with expectant parents—avoiding both false assurance or playing up their anxieties.

Some professional persons find this extremely difficult to do. They tend to avoid these issues or to brush them off when they are brought out quite openly, because they are afraid discussion will only accentuate the parents' fears. What do we do, however, when we sidestep a question, even out of the best motives? Is it not possible that evasion only makes matters worse, causing parents to think that if the doctor or nurse or social worker will not talk about something, then it is *really* something to be be feared?

We know that the number of babies born with serious disabilities is higher than it used to be, partly because of better medical care enabling many to survive who formerly would have been lost. But, fortunately, the percentages are still low compared to the total population. Statistics may reassure some, but we must recognize that parents cannot have the final answer to these anxieties until the babies are actually here. Rather, they need to be helped to live with some of these feelings and to be encouraged to know that they will manage, whatever the outcome, and that medical and social services will be available when needed.

The Dream Child

Parents are concerned, too, about the personality makeup and behavior of the baby they will have. Often they say they do not want a "spoiled child." Encouraged to describe what they mean, they say, "I don't want him to be a brat like so and so," often implying that they do not want him to get out of hand—out of *their* hand.

The concept of "spoiling" has many implications. It touches off attitudes toward methods of child care that will undoubtedly influence the handling of their babies. "If you pick them up every time they cry, aren't you giving in to them?" some parents ask. "Shouldn't they learn that they can't have everything they want, when they want it?" Such questions reveal the parents' confusion about what a baby is like and what he really needs.

Some parents tend to roll all childhood years into one stereotyped picture, failing to see that an infant's needs are different from a 3- or 5- or 15-year-old's. Often they talk of a newborn as if he were fully developed and already able to "talk back." Even before their babies are born, it is important to help young expectant parents acquire a more realistic, objective picture of what infants and children are like, separated from the fantasies that are often projections of the parents' own hopes and fears.

But this separation is not easy, especially because the baby is only a dream child during the long pregnancy. Since many parents are unprepared even for the characteristic appearance of a newborn—with his large head (compared to his small body and limbs), his often mottled skin and shock of hair (or lack of any hair), and his unresponding look, they may find the first brush with reality something of a shock. It takes time and often considerable guidance for some parents to look at their newborn objectively and to feel that this child is developing a personality of his own. They gradually come to see that their own and their children's temperaments may actually be quite different and that they are embarking on a long process in which parents and children slowly get to know one another and learn to function together.

The helping professions are generally familiar with psychodynamic concepts of variations in the development of maternal feelings, but many young parents are still caught up in the stereotyped picture of motherhood. If they fail to respond to their babies positively and with enthusiasm, many mothers feel uncomfortable and guilty because they are not feeling what they think they should be feeling. They need help to accept the fact that all mothers do not respond equally to all stages of childhood, that some enjoy their children most when they are infants while others who find the early months tedious and burdensome can barely wait till their infants become preschoolers with whom they can really talk. There is a big job to be done to give women the knowledge and feeling at every point that there are many kinds of "good mothers."

The Post-Partum Period

The adjustment often hits hardest in the first post-partum days. The hospital days are most important, for here, at least for a few days, mothers have people available to help them with their post-partum physical adjustment and their psychological and social problems. Nurses are generally alert to the feelings of letdown that so often come after the babies are born, the transient "baby blues" that many mothers have heard about. But to what extent are nurses prepared and able to take time to interpret these reactions and to help the mother regain her equilibrium? Can medical social workers be more generally involved with maternity patients with regard to their many questions and concerns about themselves and the care of the baby? To what extent are they prepared to discuss with mothers provisions for the care of other children in the family and even of household routines during the first days at home? Can arrangements be made for homemaker service, for example, if there are no appropriate relatives available to step in? Can hospital procedures be administered more flexibly so that a mother need not be pushed out routinely on the second or third day if there is some evidence that she could profit psychologically by a longer stay?

These questions arise when we consider adjusting services more sensitively to a family's psychological and social needs.

Family Planning

Parents often have an urgent need for advice about family planning. This is brought out in the weeks after delivery and also at various times during the antenatal period. In a small southwest rural community, the nurse leader was puzzled about why women who already had a number of children were making a considerable effort to attend an expectant-parent group. As she listened thoughtfully to what they were saying, she found that they knew a great deal about babies, labor, delivery, and their own reactions to pregnancy and childbirth. After a while they felt free enough to say what they really wanted—simple, factual information about conception and how it could be controlled, in keeping with their religious beliefs.

We know how much families need help in family planning, but we do not always recognize the issue unless it confronts us directly. It is not enough for services to provide contraceptive information and supplies. They must also take into account the individual and family reactions that influence a person's ability to use such information.

Particularly important to young mothers is the support they receive in the early days with the baby at home. For here their concerns about the baby are again dramatically related to themselves and their feelings of competence. If they happen to have a colicky baby (there are many infants whose intestinal tracts take time to settle down regardless of the love and sensitive handling they receive), they are naturally upset. They are distressed by the baby's discomfort and question their ability as parents because they are unable to help him. Even when the baby's days and nights go more smoothly, the first weeks at home are likely to be somewhat chaotic until the mother and father learn how to manage the many activities that make life so different from their days together before the baby came. Feeding and bathing the baby, laundry, cooking, and housework seem to be never-ending and scarcely leave time for mother and father to be together or to see family and friends.

Care in the Home

Much can be done to ease the strain by encouraging parents to consider the needs of all family members more realistically and freeing them to make choices about what they consider important and what can wait a while. The visiting nurse can be especially helpful in teaching flexible methods of physical care in the home. At the same time, through what Reva Rubin has called "creative listening,"[5] she can help mothers to gain perspective about handling the total situation. Their heavy feelings of isolation are eased by the nurse's very presence.

This period is receiving more attention from the helping professions and especially from dynamically oriented pediatricians, research psychologists, and child psychiatrists. Recent findings on the far-reaching effects on the new baby of the mother-child relationship in the first 6 months of life are vividly and convincingly portrayed in the writings of Anna Freud,[6] John Bowlby,[7] Sibylle Escalona,[8] Sylvia Brody,[9] and others. They point clearly to the need for strategic early intervention. In a workship held at the 1963 annual conference of the American Orthopsychiatric Association under the leadership of Dr. Eleanor Pavenstedt, it was recommended that a specialty be established within the helping professions to cover the field of early intervention. But we should not wait for this to be initiated. We have considerable evidence already that even limited educational intervention in the early months can have startling positive results, though some situations are so extreme that they require more extensive and intensive help.

Many persons are already in good positions to note the subtle signs of potential pathology in these early relationships and to use their knowledge and skills to keep them from developing. The public health or maternity nurse who is in contact with the mother during the antepartal and postpartal periods can play an important role in educational intervention, if she "paces" her care and guidance with the needs and movement of the patients.

Betty Highley[10] has demonstrated how this can be done in an article which describes a nurse's approach to individual mothers that is similar in many respects to the principles and goals of parent group education developed by the Child Study Association.[2] Elizabeth P. Rice,[11] discussing the social aspects of maternity care, stresses the assistance the hospital clinic team can give during the prenatal period and the days in the hospital, and the support and guidance given through some hospitals by pediatric interns who make themselves available by telephone or home visits after the mother goes home. These reports indicate a few of the changes taking place in obstetrical and neonatal care that are directed specifically to meet the psychological needs of mothers and babies.

But these changes are not enough. We need far greater recognition by *all* professional persons of the importance of the early weeks and months of the mother-child relationship. We hope that these persons, not only in clinics, hospitals, and doctors' offices but also in family and children's services, welfare departments, schools, day-care centers, church groups, and neighborhood centers, will listen to parents of young children with empathy, interest, and with sensitivity to their needs; that they will be prepared to see that parents receive additional services if needed to tide them over critical periods in family development in a way that will give them a firmer base of understanding on which to function. This is a job for all who serve mothers and children—a job that can contribute an essential element to the expanding programs of maternal and child care.

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[1] Auerbach, Aline B.: Group participation in expectant-parent classes. *Children*, May–June 1958.

[2] ———: New approaches to work with expectant parent groups—a report on a pilot leadership training program for nurses. *American Journal of Public Health*, February 1957.

[3] Caplan, Gerald: Psychological aspects of maternity care. *American Journal of Public Health*, January 1957.

[4] Wolf, Katherine M.: Unpublished material given in training programs at the Child Study Association of America, New York. 1955–57.

[5] Rubin, Reva: Maternity care in our society. *Nursing Outlook*, July 1963.

[6] Freud, Anna: The concept of developmental lines. *In* The psychoanalytic study of the child, vol. xviii, 1963. International Universities Press, New York. 1964.

[7] Bowlby, John: Maternal care and mental health. World Health Organization Technical Monograph Series No. 2, Geneva. 1951.

[8] Escalona, Sibylle K.: Patterns of infantile experience and the developmental process. *In* The psychoanalytic study of the child, vol. xviii, 1963. International Universities Press, New York. 1964.

[9] Brody, Sylvia: Preventive intervention in current problems of early childhood. *In* Prevention of mental disorders in children. (Gerald Caplan, ed.) Basic Books, New York. 1961.

[10] Highley, Betty: Antepartal nursing intervention. *Nursing Forum*, vol. II, No. 4, 1963.

[11] Rice, Elizabeth P.: Social aspects of maternity care. *Obstetrics and Gynecology*, February 1964.

FOR PARENTS

THE QUESTIONS CHILDREN ASK: And the answers to those "hard" questions about divorce, adoption, race, religion, life, and death. Murray Polner and Arthur Barron. The Macmillan Company, New York. 1964. 210 pp. $5.50.

YOU CAN RAISE YOUR HANDICAPPED CHILD. Evelyn West Ayrault. Preface by Margaret Mead. G. P. Putnam's Sons, New York. 1964. 318 pp. $5.95.

WHEN A CHILD IS DIFFERENT: A basic guide for parents and friends of mentally retarded children. Maria Egg. Introduction by Eunice Kennedy Shriver. The John Day Co., New York. 1964. 155 pp. $3.75.

THE EXPECTANT FATHER: A practical guide for future fathers. George Schaefer, M.D., and Milton Zisowitz. Simon and Schuster, New York. 1964. 157 pp. $3.95.

THE RETARDED CHILD GETS READY FOR SCHOOL. Margaret Hill. Public Affairs Committee, 381 Park Avenue South, New York, 10016. Public Affairs Pamphlet No. 349. 1963. 28 pp. 25 cents.

SMOKING—THE GREAT DILEMMA. Ruth and Edward Brecher. Public Affairs Committee, 381 Park Avenue South, New York, 10016. Public Affairs Pamphlet No. 361. 1964. 28 pp. 25 cents.

YOUR CHILD. Step by Step Toward Maturity. Dorothy Noyes Sproul. Doubleday & Co., Garden City, N.Y. 1963. 274 pp. $4.50.

A PARENT'S GUIDE TO CHILDREN'S PLAY AND RECREATION. Alvin Schwartz. Collier Books, New York. 1963. 191 pp. 95 cents (paperback).

SPEECH AND LANGUAGE DELAY: A home training program. R. Ray Battin and C. Olaf Haug. Foreword by W. Leonard Draper, M.D. Charles C Thomas, Springfield, Ill. 1964. 71 pp. $4.50.

A social worker member of a medical team discusses . . .

SOCIAL FACTORS IN TREATING BURNED CHILDREN

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A SEVERE BURN is a major catastrophe in the life of a child and may leave lasting effects upon him and his total family constellation. This paper will attempt to identify the major social and emotional implications of burns on children and will discuss the social worker's contribution as a member of the team of specialists providing care. It is based on the writer's personal experience, a review of social case records, a review of the literature, and a panel discussion on "The Burned Child" held at a nurses' program of a sectional meeting of the American College of Surgeons in Boston, March 2, 1960.*

Although medical and nursing journals contain numerous articles on the surgical and nursing techniques of treatment, there is no conclusive research to guide us in the social and emotional aspects of burns. Studies are available on the epidemiology of burns.[1, 2] A psychiatrist has written about the management of acute grief, using as some of his subjects the victims of the Cocoanut Grove fire in Boston.[3] Social work literature contains articles concerning the role social workers played in the wake of this disaster,[4] but little else.

Medical Aspects of Care

The following brief discussion of medical and nursing care for patients suffering burns will give some background for the description of the social worker's activity. Such treatment must be immediate and comprehensive. It requires a team of specialists working in a setting having extensive laboratory services, equipment, and a variety of ancillary personnel.

The physician's immediate concern is to save the child's life—rather than to concentrate on treatment of the burned areas. Intravenous fluids are frequently provided as an emergency measure even while the child is being taken to a medical center, so that precious hours are not lost before treatment is begun. Specific surgical procedures, including early skin grafting, follow according to the needs of the particular patient. Early skin grafting is an accepted procedure to foster healing, restore functioning, and improve appearance. This procedure continues over an extended period through successive stages of treatment. Although plastic surgery can do much to minimize the physical scarring, other services are needed to try to heal the spiritual scarring resulting from such severe trauma.

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*Panel members in addition to the author: John W. Chamberlain, M.D., surgeon-in-chief, Pediatric Surgical Service, Boston City Hospital; Joan Galdston, head nurse, Children's Hospital Medical Center, Boston; Donald W. MacCollum, M.D., chief plastic surgeon, Children's Hospital Medical Center, Boston; Lendon Snedeker, M.D., assistant administrator, Children's Hospital Medical Center, Boston; and Ethel Trafton, associate director, School of Nursing, Children's Hospital Medical Center, Boston.

The relationship of the nurse to the child is important in creating the most favorable climate for treatment. Sterile conditions must be maintained and intensive nursing around the clock is essential to the child's very existence. As the emergency subsides, normal channels of nutrition are resumed, with the nurse making persistent efforts to tempt the child's appetite in order to insure sufficient intake to provide a favorable atmosphere for convalescence. The nursing profession emphasizes the importance of continuity of nursing care by the same warm and loving person. The child's feelings of isolation and loneliness in the midst of pain and suffering can be mitigated by the nurse's relationship with him.

Provision of appropriate care is possible only when the necessary resources are available through the hospital's administrative machinery. The hospital nearly always has to absorb most of the cost, since it is so high that only a fraction of it can usually be paid by families or third parties, or a combination of the two. Exclusive of medical fees, the care of a severely burned child in a hospital for the first 3 months can amount to $10,000 or more. Often the required care is not available locally, so that the child must be taken to a medical facility far from the family's home. Thus the burden of expense may be borne in large measure by an institution in an area where the family has no roots.

Social and Psychological Factors

The task of describing the contribution which can be made by social work in this complicated problem is not an easy one, for there is no ready formula. No two burns are sustained in the same fashion, nor do they affect any two children in the same way physically or psychologically. Despite these differences, some characteristics seem common to all cases of severe burns. Knowing them may help the social worker care for the patient and his family.

These seven characteristics have been identified:

1. *Feelings of blame or guilt resulting from the accidental nature of the event.* Whatever the circumstances surrounding the accident, individuals or families blame themselves. Often the blame is shared by the victim—for example, the child who, having been previously warned or punished for playing with matches, disobeys and gets himself burned. I am using the term "blame" to describe the feelings of personal responsibility or self-reproach which seem to be universal in mothers when such an event occurs, the term "guilt" to describe feelings of such severe proportion as to interfere with appropriate functioning. The following two cases show this degree of guilt.

Mary, age 15 months, was just beginning to toddle and talk. While her mother was ironing, Mary grabbed the recently unplugged iron cord which was dangling to the floor. Then she did what toddlers of this age can be expected to do—put the plug in her mouth, severely burning her tongue and the roof of her mouth. She was hospitalized and fed intravenously for an extended period.

Mary progressed well. She began to eat regular food and regained the words she had lost following the accident. There was no outward sign of her injury. Although some reconstructive work is needed, her outlook is excellent. Yet, in spite of her excellent recovery, her mother is inconsolable. She maintains that she is a "nervous wreck" since the accident because she feels so guilty for her carelessness. She dwells on her feelings, does not function well, and has given over Mary's care to the child's grandmother. An adult mental hygiene clinic is now trying to alleviate her guilt feelings.

* * *

Sarah, 4½ years old, was admitted to the hospital with extensive third-degree burns. Her clothing had been ignited by lighted matches which had been thrown at her by a neighbor's child. Sarah's mother maintained that she did not feel "guilty"—her own term—but said the other child's mother did not have "a brain in her head." Actually, the mother showed in her comments and actions that she felt quite responsible for the accident, believing it was a judgment on her. She became withdrawn and bitter, stopped going to church, and became careless in her dress.

Sarah was in the hospital for 5 months. During that time the social worker saw the mother regularly, helping her to talk out her remorse, discussing her relationship with her daughter (learning that the mother felt she had always treated Sarah differently from her other children), and preparing her for the child's return home. By the time Sarah was discharged from the hospital, the situation had improved somewhat. Plans were then made for continuing to help the mother with her relationship to the child.

2. *Family anxiety over the critical condition of the patient.* When the accident occurs, just getting the patient to a place where help is available creates a crisis, for the patient usually goes into a dangerous state of shock. Moreover, many parents themselves sustain injury while extinguishing the flames. Whether or not this has happened, during the emergency admission to the hospital they can take little part in the child's care and their anxiety mounts as they stand by—waiting and idle. At this point, while the other members of the team are helping the child, the social worker might be of help to the parents.

3. *Problems related to the long-term nature of the care.* In many cases, care stretches out over many years. The acute episode usually extends for weeks or even months. During the initial period the child

is isolated from normal associations with the family and from other contacts. Extreme precautions have to be taken to control infection, and the child sees around him only people who are masked and gowned. Depending upon his age and his own past experience, the child may have fantasies about these masked faces. Even in hospitals where parents are permitted to visit freely while the children are on the danger list, the child has a feeling of isolation.

The long-term need for care extends the child's separation from family and familiar surroundings. Such separation is now generally recognized as being significant in the personality development of children. If a choice can be made, hospitalization under a certain age should be avoided. Obviously, in the circumstances under discussion, such separation cannot be avoided, so provisions need to be taken to minimize the effects and to arrange for home care as soon as possible. Furthermore, this initial separation comes without warning or preparation, provoking even greater anxiety.

While the acute period varies with each case, Leonard Colebrook of England mentions the initial hospitalization of at least 50 days' duration.[1] The writer's review of available records showed that most children remained a minimum of 4 to 5 months. Readmissions for special kinds of reconstructive services may go on for years.

4. *Deformity and disfigurement.* As the weeks and months go by and the parents begin to recover from the initial shock, they begin thinking about the child's outward appearance. At first concern for the child's life was paramount, but now they begin to wonder about the end result: How will he look? Most people are not prepared for the scarring that remains nor for the limitations in the use of affected parts of the body, both of which may require highly skilled plastic surgery for correction. One little girl in the hospital, with about 65 percent of her body burned, sat with her chin slumped on her chest, unable to raise her head. She had been burned around the neck and face, as well as elsewhere, and many complicated grafting procedures were required to help her regain anything like a normal appearance.

5. *Accompanying depression.* Most burned children appear depressed after the initial impact has subsided. One little boy seemed so quiet that his private-duty nurse wondered if he were retarded. This behavior, which continued for a month, was apparently a withdrawal symptom following the trauma, for ultimately he showed up as the lively, bright, and talkative child that he normally was.

Such is the effect of isolation, separation and anxiety, in addition to pain, immobilization and fears of disfigurement. Also, when the disaster has involved other members of the family, who were either killed or were so badly injured that they cannot visit the child, realistic fears develop that these others may have perished; this contributes to the child's depressed state. Dr. Gordon Jensen says that "the trauma of the event resulting from hospitalization, anesthesia, operations, etc., will have effects on the child's adjustment to life that cannot be overlooked." [2]

6. *Heavy expense.* Illness and accidents do not choose those people best able to meet the expense. The expense is unplanned for and can be totally devastating. While there are no studies to show whether the incidence of severe burns in children is greater in low-income families than in other economic groups, the records suggest some lack of parental supervision and poor housing. Certainly the space heater, a device often used in low-cost housing, seems to be a common cause of trouble. Dr. Jensen's study has shown that there is a greater incidence of burn accidents in the families of laborers than in the families of skilled workers. Although the exact reasons for this, he states, cannot be proven, he speculates that perhaps the skilled worker has been made more aware of safety devices.[2]

For most people family security is seriously threatened by the overwhelming costs. In fact, anxiety over the expense is expressed by some of the older children. One 10-year-old boy kept repeating, "The bill must be almost $100 now." Some families go hopelessly into debt, and cherished plans for education, housing, and other lifelong ambitions are given up following the accident.

7. *The search for blood.* Finally, there is the question of blood replacements, which in some cases is a factor in the patient's care. At best, it is a trying experience for a family to replace even small amounts of blood. If the family is large and relationships are good, the problem may not be so great. But when large amounts are needed, this is a terrible additional burden at a time when parents are least able to cope with it. It is not easy to ask someone for his blood.

The Child as an Individual

No two people react to the same set of circumstances in the same way, so it is important in any treatment plan to consider the kind of child who has suffered the burn. All of the individualizing factors about the child and his family are important in order to understand his behavior and to work toward his rehabilitation. Several of these factors seem of sufficient importance to merit specific mention here, recognizing, of course, that in each case a different configuration will exist.

Of vital significance is the age of the child when the event takes place. Erik Erikson says that in each stage of the child's chronological development there is a central emotional problem which has to be solved if the child is to go on to the next stage with vigor and confidence.[5] Think then of the interference with normal processes of growth and development when a serious burn disrupts the usual pattern of everyday life. Those aspects of childhood which we take for granted—running around freely, feeling the security of home and family life, playing with other children—are denied to the victim for extended periods of time.

Erikson particularly emphasizes the child's need to trust. If the child has already learned to trust, this will be an important factor in his care; he will be a more cooperative patient, better able to participate in the complicated routines. The groundwork for this quality of personality development is laid in the first 2 years of life.

Age is important, also, to the patient's ability to understand the reason for hospitalization and the hospital regimen. When he is too young to understand he may feel abandoned by his family, punished for a sin, or both.

The site of the burn is another factor affecting treatment. Unless corrective measures are taken, physical functioning may be severely limited when a leg or arm is seriously disabled, or the scars remaining are so unsightly as to affect the patient's feelings about himself. If the genitalia are involved, then the question of the burn as punishment assumes added significance. Family relationships, the child's previous experiences, as well as the circumstances surrounding the incident of the burn—all impinge upon the child's acceptance of his problems and his ability to use the necessary care to achieve maximum rehabilitation.

An 11-year-old epileptic boy, who was mentally retarded, sustained severe burns by falling against a hot radiator during a seizure. His mother was in another part of the house, and did not discover the accident for some time.

This child, the illegitimate son of a woman who was herself illegitimate, had been moved from one home to another by his rootless mother. He trusted no one. He was abusive and rude to the nurses and would crawl under the bed when the doctors came to do his dressings. His behavior became so disturbed that he had to be transferred to another hospital where male orderlies were available to help with his care.

This child's behavior contrasted with the behavior of children who are more intelligent and have made a better adjustment to life.

It is extremely important to understand the child's personality, his relations with his family, and the social and emotional climate to which he will return. Knowledge of the family's finances plays a part here, particularly of the sacrifices being made by other family members to provide for the victim's care. Sacrifices other than financial may be needed: for instance, changing roles within the family to permit the mother to visit the patient. Because of the patient's feelings of isolation and possible abandonment, the need for his mother to maintain communications with him is of utmost importance. This becomes difficult when other small children remain at home.

Community Resources

Going beyond the family, the social worker needs to consider the relationship of the family to the community of which it is a part. The availability of resources to meet the special needs of the child when he returns home is important and may be a factor in shortening the child's hospital stay. The length of the family's residence in the community is significant in relation to the financial responsibility which the community may be expected to bear toward the costs. The importance of availability of resources in the community to provide visiting nurse services, corrective physical therapy, home teaching, and, ultimately, vocational rehabilitation cannot be overemphasized. Beyond the local community, the Federal-State program of services for crippled children can be called on to assist families over the long pull of acute hospitalization and restorative surgery.

In light of the severity of physical, psychological, and social factors in cases of serious burns, is the outlook always grim?

A negative answer lies chiefly in the area of prevention. Many burns are preventable. The private pediatrician has a role in education for the prevention of burns. Dr. Jensen's study,[2] already mentioned, was done with the aim of developing a statement as to preventive techniques. The possibilities of preventive education by public health nurses in prenatal clinics and in child health clinics also merit consideration. The professional health educator also has a preventive role to play, as does the social worker.

Once a burn has been suffered, the outlook largely depends on the availability of appropriate comprehensive care.

Contribution of Social Work

In principle, social work activity in behalf of a burned child is the same as with any other ill or injured child. However, the specific knowledge about clinical care of these children, as well as a documentation of the anticipated social and emotional implications, may make possible a more purposeful approach to the individual patient and his family. Certainly encouragement to the family is helpful during the initial crisis when the hospital team is concerned with the lifesaving measures for the victim. Following the Cocoanut Grove fire in Boston, families benefited from having someone around who could listen and explain hospital routines.[4] The social worker can prepare families for the appearance of the patient when they first visit and for the precautionary measures necessary to control infection.

The social worker can be a helpful link between the family and the members of the medical team, sharing and receiving helpful data. Hospital personnel may be critical of parents for presumed negligence and may need to be cautioned about their own behavior, lest it affect their relationship with the parents at a time when the parents most need to be accepted. People react to stress in strange and different ways. Sometimes parents of injured children transfer their own feelings of guilt by aggressive attitudes toward the hospital staff. Unless doctors and nurses understand the reasons for this behavior, difficulties may develop and deflect energy from where it belongs—attending the patient.

A close and comforting relationship usually develops between nurse and patient during the stressful initial period of hospitalization. Although the social worker may already be in touch with the family, she is not likely to work directly with the patient at that time. As the patient approaches the more chronic stage of care, the social worker begins to see him along with the nurse, getting to know his reactions at firsthand, exploring his feelings, and obtaining insight into his relationships with his family. The patient's age has a bearing on whether communication with the social worker directly through conversation, or through play, can be most effective.

During hospitalization, the social worker can assist families and the hospital in exploring possible resources to help defray the enormous cost.

As the immediate crisis passes, the social worker continues to meet the guilt feelings and anxieties of parents as they come face to face with the awful reality of the child's problem. Where there have been disturbances in the parent-child relationship, the social worker may try to improve it during the child's hospitalization in order to promote a better home adjustment and, eventually, a happier mother and child. Where the mother has overwhelming feelings of guilt over the accident, the worker may be able to relieve these by repeatedly pointing out that one accident does not mean "a bad mother". In some cases, a parent may need psychiatric services.

In planning for continued care outside the hospital, the social worker can assist, first, by assessing the adequacy of the home for the patient's return and recommending special services and equipment. This is usually done in collaboration with a local public health nurse. The social worker can help the family anticipate the emotional needs of the child as he gradually gets better.

In consultation with the visiting nurse, the social worker can continue to help parents develop attitudes toward the child which will maintain progress—to help them realize that the child must be encouraged to do whatever he can do for himself. Care must be taken that the reactivation of parents' guilt feelings does not result in overindulgence of the child. Ultimately, the social worker's efforts need to be directed toward involving whatever appropriate local community agency can provide continuing assessment of and help with the child's progress.

To mitigate the effects of a disaster is a challenge for a team of specialists—surgeon, pediatrician, nurse, physical therapist, and social worker. All must be aware of the social and emotional implications of the disaster for the patient and his family. When they are, each member of the team can contribute his skills most effectively to the development of the most effective therapeutic program for the whole patient.

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[1] Colebrook, Leonard: The prevention of burning accidents in England and in America. *Bulletin of New York Academy of Medicine*, vol. 27, 1951.

[2] Jensen, Gordon: Preventive implications of one hundred children treated for serious burns. *Pediatrics*, April 1959.

[3] Lindemann, Erich: Symptomatology and management of acute grief. *American Journal of Psychiatry*, February 1944.

[4] Kellogg, Dorothy E.: Case Work in a hospital during the Boston disaster. *The Family*, April 1943.

[5] Erickson, Erik H.: Childhood and society. W. W. Norton & Co., New York. 1950.

FOSTER HOMES FOR TEENAGERS

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IN OREGON, where family homes are the primary source of foster care for children and adolescents needing care away from their own families, many young people are already in their teens at the time county welfare departments are confronted with their need for placement. Treatment oriented group care facilities for teenagers, especially boys, are lacking in the State. Since finding new foster homes for teenagers is especially difficult, most teenagers are placed in homes originally recruited for younger children. But even when homes are found among families who expressed a desire or preference for teenage foster children, the turnover rate is high. For example, of 95 families recruited in one 12-month period (August 1960–August 1961) only 35 were still caring for or available to teenagers in the foster care program 2 years later; and of these, 16 said that they would not be interested in caring for any other teenagers.

In view of such serious losses in foster home resources the Oregon State Public Welfare Commission conducted a review of reports on these 95 families during the 2-year period, in an effort to identify some distinguishing characteristics between those 35 homes regarded as "successful" since they were still in the foster care program and the 60 regarded as "unsuccessful" because they were no longer in the program. Of the latter, 43 had had the children removed from their homes, either at the families' request or on the welfare commission's initiative; and 17 had not been available to other placements after the young people had been released from foster care to marry, join the Armed Forces, return to their own homes, or for other reasons.

The most notable contrasts found between the "successful" and the "unsuccessful" foster families were in the nature of the role played by the foster father, the degree of warmth in the foster parents' attitudes, relationships between the foster home and the placement agency, the foster parents' attitudes toward the young people's own parents, and the number of own children in the foster parents' families. Especially obvious in the "successful" families—in contrast to the "unsuccessful"—were (1) the foster father's high degree of participation in the child's care; and (2) the foster parents' acceptance of the natural parents as significant persons in the child's life.

The reports showed that in the "successful" foster families, as a rule, the foster father was strongly masculine, definitely the head of the family, secure in his job, and well adjusted in the community. He took part in caring for the foster child, was kind but firm, and provided guidance and advice. The foster father's role was equally important in relation to foster sons and foster daughters. The typical successful foster mother was a gentle, poised woman—a good housekeeper but not a rigid one—who did not get excited when teenagers cluttered up the place.

Unsuccessful Homes

On the other hand, the reports indicated that in the "unsuccessful" foster homes warmth seemed to be lacking in both foster parents, and strict control of the teenagers tended to characterize the foster parents' treatment of the boys and girls in their care. The foster father's role as described in the reports was vague. He seldom participated in the care of the teenager or in activities with him.

Foster mothers who exhibited strong need to control constituted a definite threat to the children, especially boys, who rebelled against such control so vehemently that the placements had to be terminated. The adolescent foster children obeyed the foster fathers' orders more readily.

Foster mothers who overemphasized academic achievements were usually disappointed not only with the young person's school performance but also with the foster care program, and so terminated work with the agency.

The relationship of the foster families' children and foster children was troublesome primarily when both children were teenage girls. Their conflicts were usually emotionally charged. When both own and foster children were boys, they usually grew apart gradually in their interests.

Other characteristics noted in the "successful" foster families were:

- The family was well accepted in the neighborhood and in the community. The members made friends easily.
- The foster parents' own children seemed secure and well adjusted.
- Relationships within the family were characterized by mutual respect.
- The foster parents helped the teenager understand that he could be loved. They gave him affection without expecting immediate return. They set up clear "ground rules" for behavior but recognized the teenager's need for privacy and for group activities. They helped him with his school work, without putting on too much pressure.

The public welfare commission found that the greatest number of failures occurred among the homes in which the foster parents had four or more of their own children at home. Of the 12 such homes in which teenagers had been placed, only one was still a foster home at the end of the 2-year period.

The highest rate of success occurred among the foster parents who had no child of their own in the home. Of 31 such homes, 16 were still giving foster care at the end of the reporting period.

Of the 95 foster families reviewed, 67 had at the time of recruitment asked for specific children known to them either directly or through church, school, or neighborhood relations. Six of these families had taken in additional foster children after a successful foster care experience with the known child. Over two-thirds of the foster families that had selected the foster child dropped out of the program during the 2-year period; over half of those

(*Continued on page 243*)

INTERPERSONAL RELATIONS AND SCHOOL ACHIEVEMENT

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AT A TIME of nationwide emphasis on academic learning, a team of social scientists at the Institute for Social Research, University of Michigan, has pointed up the importance of warm interpersonal relations as the backdrop for the best use of abilities. The team's investigations show that when the classroom atmosphere is positive and supportive for all children, more children have more opportunity to realize their potentialities.

These findings will not come as a surprise to knowledgeable teachers; they will be reassuring for having emerged from a group outside the profession of education who thus might be expected to be even more objective in evaluating school activity than educators. These social scientists, headed by Ronald Lippitt, attempted to gain better understanding of the "interpersonal dynamics of the classroom as a means of enhancing learner achievement as well as improving the state of mental health of pupils." Their project, "Pupil-Teacher Adjustment and Mutual Adaptation in Creating Classroom Learning Environments," was sponsored by the U.S. Office of Education (Cooperative Research Project No. 1167) and the National Institute of Mental Health (Grant OM–376).*

Beginning with a study of the mental health problems of socially ineffective children, the researchers realized that the focus of problems was in the child's perceptions of his relations with peers, teacher, and parents. With the cooperation of 27 teachers and 727 children in the second and fifth grades and in junior and senior high school, they undertook a study of actual and perceived peer and teacher-pupil relations in the classroom; of children's perception of their parents' attitudes toward school activity; and of how these perceptions seem to relate to the use of ability.

The Child's Two Worlds

Not a small part of the contribution of the project is the sociologist's analysis of the class subculture, the child's school and family worlds, and the child's efforts to live in this life space satisfactorily. Skillfully, concepts of mental health are interwoven to show that a child at school has an internal world of his own, expressed in interests, impulses, and values; and that this world derives from two main sources: from the expectations, attitudes of and relationships with his family, and from school-world influences—the teacher's requirements, classmates' attitudes, and older peer models.

As a child tries to deal with these two worlds, five aspects appear important in shaping his reaction patterns: the similarity or dissimilarity among these influences, predictability or unpredictability in the influence pattern, acceptance or rejection of his efforts by significant adults important to him, success or failure of his performance efforts, and the perceived harmony or lack of it among significant adults.

The investigators point out that when these influences conflict, the child must devise ways to deal with them and in this he has several recourses. He may keep them compartmentalized; he may submit to the domination of one; he may reject all; he may attempt to strike a balance among them (a devastating procedure which usually fails); or he may assume personal obligation to make up his own mind, giving attention to all the contributing "voices." This last is the most mature method. One of the goals of education, the authors assert, is to help pupils discover and achieve this problem-solving, reciprocal-influence orientation, utilizing the setting for creative conflict and growth rather than disruptive demoralization and the prevention of personal identity.

To assess the effect of the peer group upon a child's mental health and achievement, the investigators used sociometric devices. An estimate of every child's social power or influence was gained through responses to the questions: "What kids in the class have a hard time—and an easy time—getting you to do what they want you to do?" "Which kids do you like and not like?" "Which kids are good at doing things you do at school?"

Two distinctly different structures were identified in classrooms: the *centrally structured*, in which loyalty and admiration on the one hand and rejection on the other focused on a few children; and the *diffusely structured*, in which loyalty and rejection are widely scattered among group members. Of particular import to teachers is the finding that *diffusely structured groups accompany more positive and supportive classroom atmospheres than the centrally structured.*

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*Fox, Robert S.; Lippitt, Ronald O.; Schmuck, Richard A.: Pupil-Teacher Adjustment and Mutual Adaptation in Creating Classroom Learning Environments. Inter-Center Program of Research on Children, Youth and Family Life, Institute for Social Research, University of Michigan, Ann Arbor. January 1964. 150 pp. Available through the U.S. Office of Education, Washington, D.C.

The investigators then analyzed social activity "output" and "input" of children—the ways they attempted to influence others and how they themselves were influenced—in order to derive characteristics which might be of use to teachers in identifying the help individuals or groups need in order to change their ways. They also devised ways to assess pupil self-perception, pupil attitude toward school, pupil perceptions of their own social positions in the class, pupil perceptions of their parents' attitudes toward school, the importance each child placed upon his parents, and changes pupils would like to see in their teachers. In addition, they observed teacher-pupil interaction in the classroom.

The spotlight on teacher behavior focused on the teacher's relation to children in the second and fifth grades. While there was little difference in the affective quality of the teacher's approach to individual children, in both grades the teacher initiated contact with boys more often than with girls. In the second grade the boys with low social power received most of this kind of attention. To achieve satisfaction in personal relations, it seems, the low-power boy has a double handicap: he must change his behavior in relation to his peers and to his teacher. The low-power girl, it was found, needs to change her behavior only in peer relations.

The investigators found that a pupil's perception of his social position in the classroom agrees in the main with his actual position; high status children perceive their high status and utilize their achievement potentials. When a child's position is low and he perceives it as low, his achievement is likely to be below his ability level.

Perceived parental support seemed especially necessary to school success at the elementary and junior high school age. Girls responded to and valued parental support more than boys, who depended more on peer approval. Pupil compatibility with the teacher and utilization of intelligence were positively related for both sexes.

Girls' performance was found to relate to social class, peer, parent, and teacher support. For boys, social class and parental support were less important than peer group status and satisfaction with the teacher.

Some Implications

The authors conclude: "Although home influences and peer group relations are related to utilization, the teacher emerges in these data as the most potent single factor in the school life of the pupil." If the pupil perceives himself disliked by his teacher, he is likely to be dissatisfied with himself and his school.

"If, as these findings indicate, successful human relations are important conditions for academic achievement," say the authors, "the teacher should try to enhance every pupil's ability to obtain emotional support from his peers by actively attempting to alter peer group sociometric arrangements."

In order to attempt this, they hold, teachers should become aware of the distribution of liking choices, and should then attempt to modify this distribution by grouping, by increasing the status of tasks given the pupils of low peer status, by teaching information about individual differences, by teaching about causes of behavior, by observing their own behavior, and by rewarding the successes of low-status children.

While in this study the use of sociometric devices proved to be revealing, some persons question the use of such devices with children because of the possibility of their increasing the very attitudes the teacher wishes to avoid or correct. Whether or not one approves of the methods of sociometry, however, one can heartily agree with the authors' emphases on the importance of the teacher's awareness of peer relationships and of securing the cooperation of parents in supporting children's educational interests.

Teachers in search of ideas for improving the human relations which support learning will find help in the three pamphlets associated with the study: "Solving Interpersonal Problems in the Classroom," "Creative Practices Developed by Teachers for Improving Classroom Atmospheres," and "Role Playing in the Classroom."[1]

For example, one teacher, noting persistent hostile action among her second graders, found that the liking and influence structures in the class formed a centralized structure, with five or six strongly rejected children and as many "leading lights."

After some thought, the teacher distributed the children into groups, each headed by a high-status child, and each containing some low-status children. The children's responsibility was to define some standards for school behavior, and to devise ways to make the classroom a better place in which to live and work. The teacher led the children to discuss, formulate ideas, draw up agreements, moving from one aspect of school to another. This resulted in a more diffuse structure of peer relationships, more happy children, and a noticeable change in attitude toward school in the formerly rejected children.

Another teacher had a fifth grade class in which children, and especially the leaders, resisted most of her suggestions. Finding that most of the class seemed to feel that it was a "bad" thing to participate or to ask for help, she started a pupil steering committee to discuss classroom behavior and publicly evaluate operations. Skillfully, she first placed high-status children on the committee, but changed membership often to effect a status mixture.

In order to bring about fairer ways of working, this teacher introduced the "observer" technique, having one child watch committee operations and conduct discussions. She herself gave some leadership training and she invited older children to help the committee over some troublesome spots, thus introducing the "older peer model." Gradually the environment became more relaxed and friendly.

In a junior high school, the teacher found his students obedient but unresponsive. The teacher devised a plan—with rewarding results—which combined pupil planning, pupil grouping, and pupil teaching.

Since these studies and accompanying experiments were carried on in schools in middle-class neighborhoods, their applicability to schools in slum areas can only be surmised.

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[1] Schmuck, Richard; Chesler, Mark; Solving interpersonal problems in the classroom. (June 1963.) Kaufman, Mabel; Schmuck, Richard; Lippitt, Ronald: Creative practices developed by teachers for improving classroom atmospheres. (September 1963.) Chesler, Mark; Fox, Robert: Role playing in the classroom. (January 1964.) Inter-Center Program of Research on Children, Youth and Family Life, Institute for Social Research, University of Michigan, Ann Arbor.

BOOK NOTES

INFANT CARE IN AN URBAN COMMUNITY. John and Elizbeth Newson. International Universities Press, New York. 1964. 268 pp. $5.

How mothers in an industrial city in England care for their babies is described in this book, which reports on detailed interviews with more than 700 mothers of babies 1 year old. Some of the interviews were supplemented by tape recordings, permitting extensive quotation of the mothers' opinions. The purpose of the interviews was to find out not only what mothers actually do but also what sources of advice influence them, how they feel about their children, and how they react to situations that arise in caring for a baby.

More than half the book is devoted to comparing families of different social classes with regard to attitudes toward childbirth and to a number of facets of baby care, such as breast and bottle feeding, use of pacifiers, and efforts to promote desirable habits of eating, sleeping, toileting, and so forth.

An unexpected finding was that breast feeding was much more prevalent and longer continued among the families of professional workers than among laborers' families. In every social group fathers were found to be taking a large share in looking after the baby though this was less common in families of laborers.

The study is the first stage in a long-term project; the next stage will be concerned with the behavior and treatment of 4-year-olds.

RACKETVILLE, SLUMTOWN, HAULBURG: an exploratory study of delinquent subcultures. Irving Spergel. Foreword by Lloyd E. Ohlin. University of Chicago Press. 1964. 211 pp. $5.

The book's thesis is that delinquent behavior is symptomatic of personality and also reflects the character of the neighborhood in which it arises. The author maintains that there are three distinct styles of delinquent life in low-income areas, each style shaped in large part by the unique structure of the area:

- In the "racket subculture" (Racketville), the best way to achieve success is to work for an organized racket. Young people are exposed to the pressure of using the abundant criminal knowledge available to them.
- The "conflict subculture" (Slumtown) is found in the worst slum. Here there are few legitimate or illegitimate ways to reach the conventional goal of success. Therefore, youths create the special opportunities and rewards of a strange way of life: gang fighting. The reputation, or "rep," of the good fighter is equated with success.
- The "theft subculture" (Haulburg) develops under social conditions where there are both conventional and criminal opportunities. While in Haulburg a well-organized crime network does not hold a dominant position, shoplifting, burglary, forgery, and the "borrowing" of cars and motor scooters provide the institutionalized means of delinquent youth to achieve status.

The book suggests ways of effecting change.

HANDBOOK OF MEDICAL SOCIOLOGY. Edited by Howard E. Freeman, Sol Levine, and Leo G. Reeder. Prentice-Hall, Englewood Cliffs, N.J. 1963. 602 pp. $11.

This book is a compilation of articles presenting information and concepts in the relationship between health and social science written largely by sociologists, with a few physicians in the field of public health. Through reviews of the literature and presentation of research findings, it shows how the fields of health and social science have grown closer in recent years:

- The medical profession has shown greater interest in studying the "whole man" and in seeking several possible causes of a single illness. During the microbiological period introduced by Pasteur, science searched hard for one cause for one disease and tended to overlook the patient in his social environment. Today, environment, genetic factors, the mental and emotional aspects of illness—all are considered by the physician. While medical science was adopting this multiple-cause approach to illness, social scientists were developing and sharpening their tools and making them available to other professions. The health field was receptive to its techniques and today social scientists are actively studying a broad range of health problems.

The book has four major divisions: "The Sociology of Illness"; "Practitioners, Patients, and Medical Settings"; "Sociology of Medical Care"; and "Strategy, Method, and Status of Medical Sociology."

The editors, social scientists, are on the faculties of the Florence Heller Graduate School of Advanced Studies in Social Welfare, Brandeis University; the School of Public Health, Harvard University; and the school of medicine and public health of the University of California at Los Angeles.

DEVELOPMENT IN EARLY CHILDHOOD: the preschool years. D. Bruce Gardner. Harper & Row, New York. 1964. 358 pp. $5.75.

The primary objectives of this textbook are to provide a general introduction to the professional field of child development and to give a concise picture of the young child as he goes about his most important task: growing. The emphasis is on the child between 2 and 6.

The author, professor of psychology at Iowa State University, sees the big job of growing as the job of achieving selfhood.

Maintaining that today's student of child development must know more than age levels and stages of human growth, Dr. Gardner emphasizes the dynamic forces underlying growth and change and the importance of understanding the unique manner of a child's movement from one stage to another.

The book is divided into four parts:

I. How We Study Children.

II. Foundations of Development.

III. Aspects of Development in the Preschool Years.

IV. The Society of the Preschool Child.

IN THE JOURNALS

High-Risk Pregnancy

The problem of high-risk pregnancy and a suggested program for improving maternal and child health services are discussed in a two-part presentation in recent issues of *The New England Journal of Medicine* by a pediatrician (part I—July 30, 1964) and two obstetricians (part II—August 6, 1964) of the Harvard Medical School. In part I ("High-Risk Pregnancy: I. Prevention of Prematurity, the *Sine Qua Non* for Reduction in Mental Retardation and Other Neurologic Disorders"), Stewart H. Clifford, M.D., analyzes data from the Boston Lying-in Hospital to show that in 21 years there has been no reduction in neonatal mortality among premature births.

The author suggests that a successful method of significantly lowering perinatal mortality and morbidity may be to identify high-risk pregnancies early in pregnancy and to separate them from the mass of normal pregnancies for special and intensive study and care, including hospitalization. This, he says, involves the problem of educating patients from certain high-risk groups based on age, parity, and socioeconomic status to seek prenatal care early and to follow through with it.

Part II considers the socioeconomic factors which point up the need for increased maternal and child health services and suggests a program for improvement. ("A Pattern of Comprehensive Maternal and Child Care," by Howard N. Jacobson, M.D., and Duncan E. Reid, M.D.) In this program:

1. The hospital would set up or make better use of the community health centers and make its facilities and consultative services available to the clinic patients.

2. Most routine maternity and child care would be rendered in these health units, thus increasing the accessibility of services and bringing medical and social care more closely together.

3. A specially trained "family nurse practitioner" would render much of the routine prenatal and postnatal care, thus freeing the physician for inhospital and consultant duties. Like the family doctor, she would be concerned with the family's total welfare.

Early Admission to School

Able children, properly selected, can enter school at an age below the usual admission age and be successful. This is the finding of the field demonstration project known as the Warren project (in Warren, Pa.) reported in the June 1964 issue of *School Life*, official journal of the U.S. Office of Education. ("Early Admission of Able Children to School," by Jack W. Birch, W. David Barney, and William J. Tisdall.)

Of 257 children listed in the preschool census results as eligible for kindergarten in the fall of 1963, all but 28 were brought by their parents for examination during 1961–62. School psychologists evaluated each child's intelligence, behavior, and social and emotional maturity. His health record was checked. The psychologists listed 37 children as "possible" candidates. These candidates visited neighborhood kindergartens where experienced teachers observed their actions. A committee studied the opinions of the psychologists and teachers and selected 26 as being ready for school a year earlier than they would normally be eligible. The parents had the final word and 19 parents said yes.

The 19 enrolled—and all went on the following year to promotion to the first grade. All but one progressed well.

Police and Juveniles

Police decisions in dealing with juvenile offenders are guided strongly by several "readily observable criteria, including boys' prior offense records, race, grooming, and demeanor," write Irving Piliavin and Scott Briar in the September 1964 issue of the *American Journal of Sociology*. ("Police Encounters With Juveniles.") Their statement is based on a study involving 9 months of observation of all juvenile officers in the police department of a medium-sized, industrial city.

The authors found that the demeanor of the young person was a major criterion in determining how the police disposed of his case. If the juvenile was contrite, respectful, afraid of what might happen to him, he was considered "salvageable"—and the police assumed that a reprimand would make him behave in the future.

The authors suggest that the higher apprehension rates for Negroes than whites could "to some extent" be traced to the fact that Negroes more often "exhibited those aspects of demeanor associated by officers with 'true' delinquent boys." They also suggest that such discriminatory practices "may well have self-fulfilling consequences . . . that frequent encounters with the police, particularly involving innocent youth, [may] increase the hostility of these youngsters to law-enforcement personnel," a reaction interpreted by the police as a sign of serious delinquency.

The Runaway Girl

"Running away from home is one of the most common forms of serious acting out in the adolescent girl," write Ames Robey, Richard J. Rosenwald, John E. Snell, and Rita E. Lee in the July 1964 issue of the *American Journal of Orthopsychiatry*. ("The Runaway Girl: A Reaction to Family Stress.") On the basis of observations of girls referred to a juvenile court, the authors conclude that running away almost always reflects severe individual or family pathology and may be caused by intolerable home situations.

The article is based on a study made at the Framingham (Mass.) Court Clinic, which serves a predominantly middle-class suburban population. During the past 10 years, 293 adolescent girls were brought into court; of these, 162 (55 percent) had run away. Forty-two of these girls and their families were referred to the clinic for further study and treatment. The authors report finding a consistent pattern of family interaction that they regard as basic to the etiology of running away—a pattern that includes "a disturbed marital relationship, inadequate control by the parents over their own and the girl's impulses, deprivation of love of the mother and subtle pressure by her on the girl to take over the maternal role."

Successful treatment of the girl, the authors maintain, depends on "simultaneous treatment of the mother."

HERE AND THERE

Federal Legislation

In August, Congress passed the Food Stamp Act of 1964 designed to permit low-income households to receive a greater share of the Nation's food, through a program to be administered by the Secretary of Agriculture. Under the program eligible households may receive allotments of coupons "which shall have a greater monetary value than their normal expenditures for food." The coupons will be good for the purchase of food from approved retail stores.

For the program the act authorizes an appropriation not to exceed $75 million for the fiscal year ending June 30, 1965, $100 million for the second year, $200 million for the third year.

The act specifies that the welfare department of each State establish standards of eligibility for participating households. Participation is to be limited to those households "whose income is determined to be a substantial limiting factor in the attainment of a nutritionally adequate diet." The standards must include "maximum income limitations consistent with the income standards used by the State agency in administration of its federally aided public assistance programs."

States or their political subdivisions are forbidden to decrease "welfare grants or other similar aid" because of participation in the food program. Discrimination because of "race, religious creed, national origin, or political beliefs" is also forbidden.

. . .

Early in October, shortly before adjourning, Congress extended for 3 years the National Defense Education Act. The new legislation broadens the program for helping States strengthen public school instruction to include English, history, geography, civics, and reading as well as science and mathematics; provides grants for training institutes for school librarians and other educational specialists; eliminates the ceiling of $800,000 on annual Federal contributions to any one institution; puts a $2,500 annual limit on loans to graduate and professional students and provides for a gradual increase in fellowships to $7,500 annually in 1967 and 1968.

Congress authorized a total of $382 million for all the act's provisions in fiscal 1965.

. . .

In mid-September, Congress appropriated $127,830,000 to finance the programs of the Children's Bureau for the fiscal year ending June 30, 1965, an increase of $28,387,000 over the 1964 appropriation. This provides for:

- Maternal and child health services: the full authorization of $35 million, $3.5 million of which is earmarked for special projects for mentally retarded children.
- Services for crippled children: the full authorization of $35 million, with $2.5 million earmarked for special projects for services for mentally retarded crippled children.
- Child welfare services: $34 million of the $40 million authorized; $4 million earmarked for day care.
- Research, training, or demonstration projects in child welfare: $5,830,000 (there is no legislative ceiling on this program).
- Special projects grants for maternity and infant care: the full authorization of $15 million.
- Research projects relating to maternal and child health and crippled children's services: $3 million of the authorized $8 million.

In addition, $4,295,000 was appropriated for salaries and expenses.

A proviso of the appropriation act states that after January 1, 1966, Federal funds shall not pay for more than half the cost of day-care services.

. . .

The Housing Act of 1964, signed by the President on September 2, includes a provision for Federal aid in the construction of low-rent housing for migrants and other domestic farm laborers. For this purpose the act authorizes expenditures of $10 million for the period ending September 30, 1965, and provides that Federal funds may be used to pay up to two-thirds of construction costs. The Farmers Home Administration, U.S. Department of Agriculture, will administer the program.

Nonprofit organizations and public agencies may receive grants for the construction of such housing if they agree to charge rents not exceeding approved scales, give domestic farm labor absolute priority of occupancy, and maintain the housing in safe and sanitary condition.

. . .

The Graduate Public Health Training Amendments of 1964, signed by President Johnson on August 27, amend the Public Health Service Act to provide for:

- Continuing the recently expired public health traineeship program for an additional 5 years, with an appropriation ceiling which increases yearly from $4.5 million for 1965 to $10 million each for 1968 and 1969.
- Extending to June 30, 1969, the program of project grants for public health training, and broadening the eligibility for these grants to include other types of agencies and institutions which provide graduate or specialized public health training, in addition to schools of public health, nursing, and engineering. The appropriation ceiling on this program increases gradually from $2.5 million for fiscal 1965 to $9 million for fiscal 1969.

Maternity Care

The possibilities of developing preventive group educational services for "high-risk" patients in federally aided maternity and infant care programs were the focus of attention at a 3-day working conference in New York in mid-September, under the sponsorship of the Child Study Association of America and the Children's Bureau. In addition to regional nursing consultants from the Children's Bureau, the participants included 27 nurses who had been trained by the Association in parent-group leadership and in group supervision. (See "Group Participation in Expectant-Parent Classes," by Aline B. Auerbach, CHILDREN, May–June 1958, p. 90.) Coming from 11 States and the District of Columbia, they were State nursing consultants, administrators and supervisors in State and county health departments, visiting nurse services, the Army Nursing Corps and the American Red Cross, and faculty members of schools of nursing.

In discussing the possibility of offering group parent education programs on a wide basis as a part of comprehensive maternal and infant care services, the participants considered various approaches to working with groups of parents of low socioeconomic status, unmarried mothers, and parents of children with mental or physical handicaps. They also discussed the implications of these approaches for the preparation of nurses to lead group programs and ways of equipping more nurses to meet the educational needs of parents, both individually and in groups.

Unmarried Mothers

Excellent school attendance and responsiveness to casework service have marked the first year and a half of a demonstration project to provide comprehensive medical, educational, and mental health services for unwed pregnant adolescents in Chicago, according to the project's coordinator, Paulette Hartrich. Operated by the Mental Health Division of the Chicago Board of Health, with a grant from the National Institute of Mental Health, the project began in April 1963 and will continue through January 1966. Its central feature is a special, accredited elementary school to which girls are transferred when they are excluded from regular school because of pregnancy; the teacher is provided by the Board of Education.

Besides Mrs. Hartrich, who is also a staff member of the Mental Health Division, the project staff consists of a codirector who is a social worker, another full-time social worker, a half-time psychologist, and a part-time psychiatrist. Harold Visotsky, director of the Illinois Department of Mental Health, is the principal investigator and project director. Medical care is provided by the Infant Welfare Stations of the Board of Health, the Chicago Lying In Hospital, and several other local hospitals. The project offices and the neighborhood YWCA, which contributed space for the special school, are both located in a public housing project in a depressed area with high illegitimacy rates.

In the first year of service, the project accepted 35 girls and their families and rejected 77, the largest single reason for rejection being the advanced stage of pregnancy. The girls accepted ranged in age from 11 to 15, nearly half being 14. Sixteen were living with both parents; 19 with a mother or grandmother. Thirteen had themselves been born out of wedlock. Twenty-eight were in the eighth grade; only 1 had an IQ over 100. At the end of the first year, 14 were no longer in the project school: 11 had returned to regular school after delivery; 3 had been dropped from the project school because of serious health or emotional problems—ultimately 2 of these were helped to return to regular school.

Mrs. Hartrich reports that the project's social worker has had no difficulty keeping in touch with the girls after they left the project school; that the mothers of these girls, "contrary to popular opinion," were distressed by the pregnancies but saw themselves as "helpless to intervene and overwhelmed and victimized by an unfriendly fate"; and that these mothers believed strongly that it is immoral to place a baby in adoption, "to throw away your own flesh and blood."

Mrs. Hartrich also reports that the project has found community support "both through individual volunteers and organized groups" to be readily available and "proving vital to the success of the overall program."

Venereal Disease

The venereal disease rate is rising throughout the world, especially among young people, according to a 1964 report of the United Nations World Health Organization. ("Review of the Organization's Programme in Endemic Treponematoses and Venereal Infections.")

The report points out that a WHO study of long-term trends in early syphilis showed that in 76 out of 105 countries and areas a persistent rising incidence trend followed an all-time low after 1955. In some countries, the greatest increase has been among the young. For example, in Czechoslovakia, 4.4 percent of the cases of syphilis reported in 1955 occurred in the 15–19 age bracket; in 1959, the proportion of cases had climbed to 13.3 percent. In Canada, the rate per 100,000 young people 15 to 19 rose from 5.8 in 1959 to 8.3 per 100,000 in 1962. (The U.S. Public Health Service reports that in 1959 the U.S. rate was 12.9 per 100,000 youngsters 15 to 19; in 1961, it was 24.2.)

The WHO report attributes the rise in the venereal disease rate to industrialization, urbanization, rising prosperity, the large movement of people by land, sea, and air, and changes in young people's code of behavior. Paradoxically, the report says, the early success of penicillin contributed to today's problem, by producing "a false sense of security."

The report emphasizes that penicillin is inexpensive and, if administered properly, effective against syphilis. What is needed is determined application in public health programs of knowledge already available—and surveillance, intensified care, and the bringing in of greater numbers of infected persons for adequate treatment.

More progress is reported against the nonvenereal endemic treponematoses of childhood—endemic syphilis, pinta, and yaws, the most prevalent. Countries that have undertaken mass treatment campaigns against the nonvenereal treponematoses in rural areas where they are endemic have reduced the prevalence of these diseases from 25 to 1 percent of the rural population.

Conference on Genetics

The importance of genetic consultation in planning and carrying out maternal and child health and crippled children's programs was underscored at a 2-day conference on human genetics and public health held on August 10–12 in Minneapolis. It was sponsored by the University of Minnesota School of Public Health, the Minnesota State Department of Health, and the Federal Children's Bureau. The 75 participants from 32 States included experts in human genetics, directors of maternal and child health and crippled children's services, professors of maternal and child health, and deans of schools of public health. Purpose of the conference, which was conceived and planned in large part by Lee E. Schacht, supervisor of the human genetics unit of the Minnesota State Department of Health, was to consider the relevance of the principles of human genetics for improving service programs for mothers and children.

In the morning sessions four geneticists—Dr. Schacht, Sheldon Reed, director of the Dight Institute of Human Genetics, H. O. Goodman of the Bowman Gray School of Medicine, and James R. Miller of the University of British

Columbia School of Medicine—described the basic concepts of human genetics as they relate to public health, their direct application in programs now under way, and their application to public health research as illustrated by the genetic register in use in British Columbia. In addition there were panel discussions of genetic counseling; the courses in genetics now offered by schools in public health; and the genetic programs in specific State agencies and institutions.

In the afternoons four discussion groups considered three questions: (1) the need for formal instruction in genetics by persons administering public health programs; (2) the application of human genetics to State maternal and child health and crippled children's programs; and (3) the kind of personnel needed for applying genetic concepts to such public health activities. Among their recommendations were the inclusion of geneticists on the professional teams which plan programs and on the clinical teams caring for children with hereditary diseases and of genetic content in public health curricula.

Full proceedings of the conference will be published soon by the Minnesota State Department of Health.

Human Rights

For 5 days last August, 150 teenagers, representing a cross section of this country's ethnic groups, met in Princeton, N.J., under the sponsorship of the National Social Welfare Assembly to discuss how they could work as individuals and organization members to improve conditions for minorities in their own communities. Drawn from youth organizations sponsored by national, State, and local agencies and religious groups, the delegates came from cities, towns, and rural areas in 35 States, Puerto Rico, the Virgin Islands, and the District of Columbia. Also attending were 25 adults—staff members, volunteer advisers, and speakers from government agencies and human rights organizations.

Divided into 13 discussion groups, the teenagers talked about the relationship between human rights and housing, employment, education, politics, and law. Emphasizing the importance of education and broader social contacts in breaking down barriers to understanding, they planned to suggest to school authorities the study of the history of minority groups, to promote intercultural programs, to set up human rights committees in student government, to urge assembly programs devoted to human rights problems, and to work with parent-teacher and parent-student-teacher associations.

A working session of the National Teenage Conference on Human Rights.

To combat the problem of unemployment among youth, the delegates recommended asking their schools to get more vocational counselors. For their part, they suggested learning what their communities are doing to increase job opportunities for youth and to join those agencies and organizations working to find young people jobs.

The discussion group on housing indicted *de facto* segregation and outlined a plan of action: to prepare lists for minority groups of available housing and encourage people in rundown neighborhoods to move into better ones—and to persuade landlords in the better neighborhoods to accept those who want to move in; to alert their neighborhood to the scare activities of "blockbusters"; to talk to their parents about the housing problems of minorities and to ask them to talk to their friends about it; to urge church and civic organizations to work harder to improve housing conditions; and to cooperate in neighborhood beautification projects.

In the world of politics, the teenagers saw themselves assisting in voter registration and education, babysitting or providing transportation for those who want to register or vote, distributing literature in their neighborhoods, and writing to editors and legislators about human rights problems.

The delegates assigned a large role to religion in correcting some of society's injustices. They promised to work for interfaith and interracial social gatherings, panel discussions in churches, schools, youth organizations, and interfaith tours of churches and synagogues.

One youngster summed up his conference experience: "If we can live in an ideal community like this has been, then there is hope, and it gives me the courage to stand up and speak. When I get back to school and in my classes and other places where people or even teachers make statements I know are wrong, I'm going to speak out . . . believe me."

Accident Prevention

A 3-year project in suburban Rockland County, N.Y., to test the effects of a health education program for parents on the incidence of accidental injuries to children under 7 brought "no apparent changes in the study *versus* the control groups during or following the educational program," according to the study report. ("Rockland County Child Injury Prevention Project.") The study was financed by a grant (00056–04) from the U.S. Public Health Service and was conducted by State and county health officials.

In 1963 about one-quarter of Rockland County's population of around 167,000 was under 7. For the study, recent housing developments occupied largely by young white-collar families were divided into two similar areas, separated by a limited-access parkway and a buffer zone. Families in the study (4,041 homes) were exposed to an education program lasting 18 months; families in the control area (4,063 homes) received no information and were not informed of the program. The chief methods used in the study program were the holding of neighborhood discussion groups, film showings, and the distribution of a monthly newsletter and other literature; 350 volunteers from the area participated.

Accidental injuries were recorded on special reports by physicians, dentists, and the staffs of hospital emergency rooms. Actually, there was a sharp decline in accidents during the second half of the education phase—but this was true too for the control group.

Handicapped Children

The parents of a newborn child with cleft lip and palate are apt to experience a high level of anxiety concerning his condition, have guilt feelings about it, and worry about having other children, according to a study conducted during July and August 1963 by the Crippled Children's Services, Minnesota State Department of Public Welfare.

The mothers of 51 children attending the facial-dental clinics were interviewed in their homes by social work trainees, first orally by way of introduction, and then through a checklist questionnaire containing 23 questions concerning events and feelings connected with the birth of the affected child. These questions were both open-end ("What did your husband's feelings about the baby seem to be?") and closed-end ("Who was told first about the baby's condition, you or your husband?").

The checklist contained two parts: (1) a 4-page "index of impact," containing 34 questions designed to get at the amount of stress associated with the child's condition; (2) a 1-page "marital inventory" to get at the tone of relationship between the child's parents.

The impact index revealed the following patterns:

- Parents who are young at the time of the child's birth are likely to experience greater stress on learning about the impairment.
- Highly stressed families tend to be those with fewer other children.
- The type of cleft condition seems to have some relation to the degree of

JOINT PERINATAL-POSTNEONATAL MORTALITY RATE

United States and Selected Countries, 1959–61

Country	Joint rate 1959–61	Percent reduction from 1954–56
Sweden	29. 8	−13. 1
Norway	31. 6	−11. 2
Netherlands	32. 6	−14. 7
Switzerland (1959–60)	33. 0	−18. 5
Denmark	34. 8	−19. 8
Finland	34. 9	−20. 5
Australia (1959)	35. 3	−4. 9
New Zealand including Maori	36. 9	−8. 7
United States	37. 6	−3. 4
Canada	40. 9	−12. 8
United Kingdom, except Northern Ireland	42. 0	−11. 6
Luxembourg	47. 7	−15. 6
Federal Republic of Germany	47. 7	−20. 1
Japan	60. 1	−15. 1

The above table is based on a special analysis made by the Children's Bureau of a number of countries' 1959–61 infant mortality levels in the perinatal and postneonatal periods considered jointly. The joint rate gives an overview of mortality during the birth period and throughout infancy. Perinatal deaths included are deaths of live born infants under 28 days of postnatal age, and fetal deaths in pregnancies of at least 28 weeks of gestation, including those for which duration was unreported. The joint rate is number of perinatal plus postneonatal deaths (1–11 months) per 1,000 total births, live and still. Countries included are those with relatively advanced economies, well-developed vital record systems, and population of 300,000 or more.

Eight countries in 1959–61 had lower joint perinatal-postneonatal rates than those prevailing in the United States. In this group New Zealand's lead was not quite large enough for statistical significance, but its more rapid pace of reduction since 1954–56 indicates a widening difference if the trend continues.

The small U.S. reduction in joint perinatal-postneonatal mortality in the latter half of the 1950's, 3.4 percent, was entirely in the perinatal period, and principally just before and during birth. The fetal death rate in 1959–61 dropped 7 percent from 1954–56, in comparison with a 1.6 percent decrease of the neonatal death rate (under 28 days). The postneonatal rate remained unchanged, 7.3 per 1,000 live births, in both periods, and more than double the postneonatal rate in Sweden, 3.2 per 1,000 in 1959–61; it is also significantly higher than the rates in 8 other countries—the Netherlands, 4.5 per 1,000; Switzerland, 5.4 (1959–60); Denmark, 5.7; Australia, 5.8; Norway, 6.3; United Kingdom, 6.5; and Finland, 6.7.

The data for the United States are those of the National Center for Health Statistics. For other countries the sources of data were: the Demographic Yearbooks, Statistical Office of the United Nations; the World Health Organization Epidemiological and Vital Statistics Reports, and official reports of some of the countries.

Certain limitations of these data for different countries are noted in the current Children's Bureau statistical series, "Trends in Infant and Childhood Mortality, 1961." (October 1964.)

—Eleanor P. Hunt

stress, a cleft lip alone being less traumatizing to the family than a cleft palate or both together, since it brings fewer feeding, speech, and dental problems.

Many mothers reported feeding problems: Only 16 said they had no feeding problem; 31 said that the affected child had been harder to take care of than their other children.

In regard to a main concern of the study—to determine the efficacy of early counseling for the parents of children with cleft lip or palate—the researchers found that while all the parents received counseling through the family physician and the plastic surgeon, eight mothers, when asked who had helped the most with their problems, said "no one." Asked who had given them most information, five mothers said "no one." Seven others reported looking for answers in books.

The researchers conclude: ". . . many of these mothers were not ready to accept explanations until they had had a chance to vent some of their own anxiety."

Eighteen mothers (35 percent) said they had guilt feelings at the birth of the child; 4 of them said these feelings were strong. Thirteen reported that their husbands experienced similar feelings. Nineteen mothers spoke of worrying about the reactions of friends and relatives to the child: 35 said they worried about having more children because of the impairment.

The researchers suggest that much parental anxiety could be alleviated if the problems connected with the child's condition are dealt with as soon after birth as possible, through the services of a hospital team including a medical social worker, family doctor, plastic surgeon, public health nurse, and possibly a geneticist.

The study was carried out under the supervision of Mildred Norval, M.D., director of the State Crippled Children's Services, Thelma Larson, medical social worker, and Peter Parshall, research assistant.

Vaccines

The Agency for International Development, U.S. Department of State, recently signed an agreement with representatives of six West African countries to assist in conducting a measles control program in 1964–65. The countries are the Ivory Coast, Dahomey, Niger, Mali, Guinea, and Mauritania. In West Africa measles is the biggest killer of children. Many children suffer from malnutrition, which probably contributes to the severity of the disease and to the occurrence of complications such as pneumonia.

The new program will involve approximately 1 million children, one-quarter of the susceptible population, and will be conducted from November 1, 1964, through January 31, 1965. Health personnel of the African countries, trained by American experts, will do the inoculations. The recently developed measles vaccine is expected to immunize for life.

This program follows a series of both pilot and mass immunization projects conducted in Upper Volta in 1962 by scientists of the National Institutes of Health, U.S. Public Health Service, and the Government of Upper Volta. (See CHILDREN, July–August 1962, page 166.) At that time a team of American and local doctors vaccinated about 731,000 children. Using a hypospray jet injector that pressed the vaccine through the skin, they inoculated as many as a thousand children in an hour. Before this program, one of every four children born in Upper Volta, a nation of about 4,500,000 people, died of measles. In the epidemics that usually struck in the spring, as many as half the stricken children died. Today there are relatively few cases of measles in Upper Volta.

Child Welfare

In an effort to discover how adoptions turn out and why they turn out the way they do, the Illinois Children's Home and Aid Society, with support from the Children's Bureau, has recently begun a study of 200 children who have been adopted through the society. The research team is planning to interview the adoptive parents of all children who as infants were placed in adoption during the years 1954 through 1958 in families in which there were no other children. The team will seek to identify factors associated with good or poor adjustment of children placed in adoption and, in relation to each child, to determine whether or not such factors were known to the agency at the time the child was placed.

. . .

A series of workshops for foster parents, consisting of six monthly sessions designed to give them a clearer conception of their role, build their esprit, and improve the quality of the care they provide has recently been conducted by the El Paso County (Colorado Springs, Colo.) Department of Public Welfare. The agency made it clear that attendance was considered a part of the job performance. Child welfare workers were also expected to attend.

The foster parents were drawn into the preparation of the program through individual discussions with their caseworkers and through three letters sent to them at intervals from the agency. The letters were designed to announce the workshop, to solicit preferences for discussion, and to provide background information. Reading materials provided included excerpts from social work literature and a *Workshop Bulletin* prepared especially for each session.

Fifty-five of the agency's 60 foster families were represented at the sessions, with 50 percent of the fathers attending at least 1 of the 2 evening meetings.

The agency chose to experiment with a "structured approach." Thus each session consisted of 1½ hours of instruction followed by 20 minutes of discussion. Topics of the sessions were: (1) Foster Boarding Care—A Professional Service; (2) Foster Boarding Care—A Partnership with the Agency; (3) Foster Boarding Parents, Caseworker—An Inseparable Team; (4) The Foster Child, Who Is He? (5) What Do Foster Boarding Parents Mean to the Foster Child? (6) What Does the Caseworker Mean to the Foster Child?

Foster Homes

(*Continued from page 234*)

foster families that had taken the child selected by the agency left the program.

In view of the extreme shortage of foster care facilities for this age group, purposeful selection of suitable foster family homes at the present appears to be a necessity because no other adequate resources are available in sufficient quantity. However, foster family homes offer more than a placement of necessity for those adolescents who need a family environment. They offer a placement with purpose.

READERS' EXCHANGE

FANSHEL: *Author defends data*

In his review of my book, "Shared Fate," David Fanshel has sought to give the impression that my theory of adoptive relations is not based on reliable research results, but is a figment of the author's imagination. ["An Upsurge of Interest in Adoption," CHILDREN, September–October 1964.]

In the early chapters of "Shared Fate" information is brought together to show that various circumstances tend to handicap adopters in their performances of parenthood. Among these handicapping factors are the attitudes of the community. This idea of role handicap is readily dismissable, says Professor Fanshel, since "the data . . . are sketchy and some of the responses may have been conditioned by the somewhat dramatic activity of the researcher . . . (such as his) method of making use of his own status as an adoptive parent . . . ." The reviewer goes on to say that such procedures are known to influence people to give *invalid* responses to research questions.

Now the passages to which Professor Fanshel refers bear re-reading. The facts are quite different from the impression given of them in the review. An unintended dramatic event (not a "method") that took place during a pretest of a questionnaire provided certain insights about some of the early experiences of adopters. (See "Shared Fate," pp. 53–56.) These insights were subsequently put to use in a mail questionnaire that asked couples to indicate whether certain statements and questions had been addressed to them and, if so, how often. In that context the author's own attitudes and experiences are entirely irrelevant.

Professor Fanshel is presumably competent to understand the technical procedures that were used in the analysis of the results from this questionnaire study. Why then, if he considered the data "faulty" but my interpretation of them "eloquent," did he make no reference to these candidly reported procedures of analysis?

The replies to 11 of the items presented to adopters in the questionnaire formed a Guttman scale of high reproducibility. This finding provides strong evidence that the responses are representative of genuine social experience, and so supports the validity of the data. Besides, the answers from seven samples of adoptive parents in five regions across this continent were remarkably uniform, indicating that there exists a cultural climate of misunderstandings concerning adoptive relations. (See "Shared Fate," pp. 30, 175–176.)

The review contains other, and similarly misleading, criticisms that cannot be dealt with here because of lack of space. But perhaps I am not without responsibility for any misreading of "Shared Fate." Academic and professional people are prone to a trained incapacity for fusing systematic thought with imaginative expression, and they tend to suspect the objectivity of whoever makes the attempt.

H. David Kirk
Professor of Sociology, University of Waterloo, Waterloo, Canada

EISENBERG: *Is research necessary?*

In reference to Leon Eisenberg's comprehensive evaluation of drug treatment of children by structured research programs ["Role of Drugs in Treating Disturbed Children," CHILDREN, September-October 1964], I should like to point out that a great deal is known about drugs from clinical experience in hospitals, clinics, and private practice.

For example, the effectiveness of benzedrine and dexedrine in hyperkinetic, impulsive, distractible children and in children who are sex driven, enuretic, or depressed and anxious, or have learning problems or school phobias, has been recognized for more than 30 years. The use of anticonvulsive drugs to modify behavior in children with convulsive disorders or organic brain disorders has also been known. Benadryl, after it was found useful to children with allergies, has been used effectively in the treatment of disorganized, neurotic, and anxious children for more than 10 years.

Even the phenothiazines and reserpine have been used clinically with children long enough to prove their worth. Hospital and institutional life is a much more normal and therapeutic experience for children since these drugs are used. Children's stay in a hospital is often reduced to months now, where drugs are used, from what used to be years.

Treating children with placebos and blindly seems to me incorrect. Some research programs demand this, and I am grateful to Dr. Eisenberg and others for carrying them out. However, to my knowledge this research has contributed nothing so far that has not already been known from clinical experience.

No child is a test tube into which one can pour a chemical and expect to get a known reaction. Drugs must always be a part of a treatment program, and one should know what kind of child is being treated with a specific medication. Therefore, one should not treat a child blindly.

The toxicity of drugs is rightly feared. But should research not be as explicit and careful in statements concerning the toxicity of drugs, as concerning their effectiveness? Blood dyscrasias and jaundice have been reported in adults, but are they known in children? I have never seen a child with either condition when the condition was not otherwise explained. Drowsiness occurs either transiently or as a result of too much or inappropriate medication. In the use of phenothiazines, trismus and torticollis, or even convulsive phenomena, disappear within an hour or two if the drug is not repeated. These behavior responses are also of diagnostic significance which should not be undervalued. Extrapyramidal features in children occur with some drugs after continued use and appear to be an accentuation of underlying neurological instability.

It should be emphasized that children before puberty react differently to drugs than adolescents, who are more like adults. Disturbed children in a treatment program respond to carefully individualized drug treatment which helps them behave and mature and benefit from appropriate educational, social, and therapeutic experiences.

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FACTS FOR TEENAGERS: SMOKING, HEALTH, AND YOU. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 424. 1964. 22 pp. 15 cents.

YOUR TEENAGE CHILDREN AND SMOKING. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 423. 1964. 13 pp. 15 cents.

Both these pamphlets are an outgrowth of the National Conference on Smoking and Youth convened in Washington, D.C., in the spring of 1964. (See CHILDREN, July–August 1964, pp. 157–158.) The first, directed to adolescents, is based on suggestions made by 170 young people between 12 and 15 years of age during its preparation. It presents a number of questions teenagers might ask about smoking, with brief factual answers; a brief discussion of the Surgeon's General report, "Smoking and Health"; and a summary of medical evidence linking smoking with lung cancer and other respiratory diseases. The second, addressed to parents, presents ideas for helping a child make a negative decision about smoking.

SERVICES FOR CRIPPLED CHILDREN. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 38. Revised 1964. 26 pp. 15 cents.

Explains the kinds of services rendered to handicapped children by State crippled children's agencies and the part played by the Federal Government in helping to support these services. Included are a list of the State agencies involved and the amounts of the Federal grants they received in 1964.

WHEN TEENAGERS TAKE CARE OF CHILDREN; a guide for babysitters. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau; and Public Health Service, Division of Accident Prevention. CB Publication No. 409; PHS Publication No. 1179. 1964. 60 pp. 25 cents.

Written as a guide for teenage babysitters, this handbook emphasizes responsibility for the physical safety of children in their care as the most important part of the teenage sitter's job and offers suggestions to prevent accidents. It also makes some suggestions about how to get along with parents, handle emergencies, and cope with the variety of physical needs and personality problems of children.

RESEARCH RELATING TO CHILDREN, Bulletin No. 17 (February 1963–February 1964). Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1964. 124 pp. 75 cents.

As in previous issues, this bulletin lists the research projects in progress or very recently completed which were reported to the Clearinghouse for Research in Child Life during the designated period. Subject areas are: growth and development; personality and adjustment; educational process; exceptional children; the child in the family; social, economic, and cultural influences; health services and surveys; and social services.

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